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GROUP PSYCHOTHERAPY IN AN ARMY GENERAL HOSPITAL

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THE treatment of psychoneurotic casualties at general hospitals near the zone of combat has produced remarkable results.[1] The patients who are evacuated to the States present, however, a more difficult problem. Their symptoms, originally acute psychosomatic manifestations of fear, have become fixed and have assumed a new function. They have become unconsciously of value as a means of escape from danger, injury, and death.

During the past year a considerable number of psychoneurotic soldiers, evacuated from the various battle fronts, have been admitted to our hospital. Most of them exhibit anxiety symptoms reflecting a sense of insecurity and fear. Their thinking reveals evidence of a regressive trend as manifested in preoccupation with their symptoms and a concomitant diminution in their sense of social responsibility. Torn away from their homes and peaceful surroundings, they become frightened and hostile. To many of them the world situation is but a nebulous foreign affair with which they are personally entirely unconcerned.

The negative attitude of these patients toward further service in the army is far out of proportion to the severity of their ailments. They reveal little drive to get well, and rationalize their attitude with "I have done my share," or, "I will be much more useful in civilian life." Some of them

[1] See *War Neuroses in North Africa*, by Lieutenant Colonel Ray P. Grinker and Captain John P. Spiegel. New York: Josiah Macy Jr. Foundation, 1943.

are convinced that they are very ill, and look forward to further periods of "rest."

It has been erroneously believed that the moment these patients are discharged from the army, they rush immediately for jobs in the coveted defense industries. Studies in England,[1] observations in the United States,[2] and letters received from our own patients reveal that this is not always the case and that, instead, many of these soldiers are quite incapacitated.

Most army hospitals, cognizant of the deteriorating effects of inactivity, have instituted recreational activities, craft work, and occupational therapy for the neuropsychiatric patients awaiting disposition.[3] Valuable as these activities are in maintaining the morale of the patients, it is obvious that they do not fully meet the problem of rehabilitation. These patients are anxious and bewildered. They have lost their self-confidence. Many of them are depressed and imbued with a feeling of guilt. They are badly in need of psychotherapy.

Aware of the urgent need of treatment and encouraged by the favorable results reported in the literature,[4] we initiated a program of group psychotherapy during the early months of 1943. Groups of patients have been meeting two or three times a week for a period extending from four to six weeks. The patients selected for treatment have all been in combat either in the Mediterranean or in the South Pacific theater of war. Mental defectives and antisocial psychopaths have

[1] See "Social Effects of Neurosis," by Aubrey Lewis. *The Lancet*, Vol. 244, pp. 167–170, February 6, 1943.

[2] See "The Unfit: How to Exclude Them and How to Use Them." Proceedings of the Military Session of the American Society for Research in Psychosomatic Problems, Detroit, May 9, 1943. *Psychosomatic Medicine*, Vol. 5, pp. 323–63, October, 1943.

[3] See "The Military Psychiatrist," by Lieutenant Colonel William C. Menninger (*Bulletin of the Menninger Clinic*, Vol. 7, pp. 129–36, July, 1943) and "Therapeutic Considerations for Army Psychiatrists," by Lieutenant Colonel William C. Porter, Captain John G. Novak, and First Lieutenant Paul V. Lemkau (*The Military Surgeon*, Vol. 92, pp. 372–79, April, 1943).

[4] See "Group Psychotherapy for War Neurosis," by Major Donald Blair (*The Lancet*, Vol. 244, pp. 204–05, February 13, 1943); "Group Psychotherapy," by Maxwell Jones (*British Medical Journal*, pp. 276–78, September 5, 1942); and "Mass Psychotherapy," by E. N. Snowden (*The Lancet*, Vol. 239, pp. 769–70, December 21, 1940).

been excluded for obvious reasons. Each patient has been previously interviewed, his complete history obtained, and a mental status formulated.

The group is assembled in a room set up as a living room. The atmosphere is congenial and informal. Everything possible is done to insure relaxation. In a brief introductory talk, the patients are reassured. They are told that they will not be returned to the battle front and that, from the point of view of defense, they will be just as useful in noncombat units. They are urged to express themselves freely and are told that the road to well-being lies not in forgetting, but in learning how to face their terrifying memories calmly and courageously.

During the first two or three sessions, each patient is asked to describe the circumstances that led to the development of his nervous state. The aggressive, extroverted patients are called upon first. The timid and the withdrawn then follow with comparative ease. Their spontaneous narratives, told in simple language and often charged with emotion, are always dramatic and are frequently interspersed with tragic incidents. The contrast between the types of warfare prevailing in different theaters of war heightens the interest and helps maintain an animated atmosphere.

It is remarkable how patients who, when individually interviewed, are reluctant to discuss their terrifying past change their attitude during the group sessions. Surrounded by other patients who manifest symptoms similar to their own, most of them lose their sense of inferiority. They talk much more freely about their painful experiences and reveal the inner turmoil they previously tried to repress.

The effect of the group on the individual patient is strikingly illustrated in the following case:

> One of the patients had been evacuated from the Southwest Pacific because he had jumped out of his fox hole at dawn and begun to shoot blindly, obviously in a state of frightful confusion. During his stay in the hospital, he constantly complained of headaches, restlessness, and inability to tolerate the least noise. His hands were wet with perspiration. He was tremulous to a point where, on touching him, one could sense the vibrations of his entire body. He did not like to talk of his experiences. During one of our group sessions, however, he unhesitatingly told the following story:
>
> He was with another soldier and a doctor in a fox hole in the depth

of the jungle. The stillness of the night was disturbed from time to time by the shrieks of the Japs, who were obviously attempting to break the morale of the American soldiers. The Americans had been instructed not to shoot under any circumstances. They were imbued with the fear that a Jap might jump into a fox hole and attack them with his knife. They, too, were supplied with knives, ready to use them for defense at the slightest provocation.

During the night the doctor was very nervous. He kept touching and counting the legs of his companions in an effort to reassure himself no Jap was present in the fox hole. He was exceedingly restless, and his restlessness affected his companions and kept them on edge. Suddenly the doctor screamed, jumped to his feet, and began to swing with his knife. There was general confusion. A terrific scramble ensued as the occupants of the fox hole clashed with their knives.

The patient did not remember what happened until he awoke in the hospital and found himself on a cot next to the doctor. The latter was badly cut up. He told the patient that the reason he had become panicky was that he had counted seven legs in the fox hole. The patient felt extremely guilty, convinced that he had been the one who had wounded the doctor.

When the patient had ended the story, there was a spontaneous outburst of laughter, such as is so often provoked by a comical incident in a weird and uncanny situation filled with danger and suspense. The patient was momentarily startled, but immediately relaxed and smiled. The paradoxical reaction evoked among his listeners by the tragic content of his story obviously brought about at least a temporary relief from guilt and anxiety.

The attitudes and reactions of the patients toward their experiences vary greatly. Some of them become markedly tense, agitated, and tremulous while relating their stories. They are bewildered, apologetic, and often depressed. They dramatize their experiences. They assert their loyalty and patriotism, and at the same time often express a feeling of futility. They dwell upon the great strain experienced in the face of impending dissolution and death. Their thought content reflects an underlying conflict between their desire to escape death and a sense of duty toward their comrades and their country.

Other patients externalize their conflicts. They are hostile, bitter, resentful, and disgusted. They tend to project their sense of fear, inadequacy, and guilt by blaming their superiors, their lack of training, and the superiority of the enemies' equipment. These patients are inwardly insecure and self-absorbed and outwardly aggressive individuals, whose sense of social responsibility has been poorly developed in contrast to their hypertrophied self-estimation.

Still others assert with resignation that they have been nervous all their lives. They complain that exhaustion, fatigue, illness, separation from family, loss of hope, and finally anticipation of death have accentuated their lifelong sense of insecurity to an intolerable degree, throwing them into a panic and bringing about final collapse. These patients have accepted their lifelong inadequacy, and experience little conflict. They often reveal a history of daily sick-call attendance long before they reached actual combat. They are intensely unhappy while on active duty. They tremble violently at the thought of combat and accept their "illness" with great relief.

Finally, there is a small group of patients, fundamentally stable, whose prolonged endurance of terrifying experiences is ample proof of their bravery. These men, after a period of rest, usually request return to full-duty status. They do not reveal overtly any emotional tension, although some of them exhibit objective signs of a disturbed vegetative nervous system, such as tremors, palmar sweating, and so on. The reasons they give for their desire to return to duty are usually conventional. They are wholesome, unassuming individuals. Their background, strangely enough, reveals little aggression; they come from well-integrated families, and have a strong sense of social responsibility. The stories told by such patients produce a profound impression on the rest of the group. They evoke a great many comments that are illuminating and instructive.

The following is a brief account of the experience of one of these men:

> The patient, a twenty-three-year-old soldier, had been evacuated from the South Pacific area with a diagnosis of psychoneurosis, anxiety state. He came from a moderately well-to-do-family. His father was a machinist. His older brother was in the navy. He himself had been an apprentice machinist prior to induction into the army.
>
> In January, 1943, he was on Guadalcanal. His company was outnumbered and outflanked. The company commander asked for volunteers to hold off the enemy while the bulk of the men made an attempt to retire. Four men stepped forward, the patient among them. Armed with a machine gun, they stepped cautiously forward to meet the enemy. They were greeted with an outburst of machine-gun fire and two of them were instantly killed.
>
> The patient and his buddy ran toward a fox hole. The patient reached it alone. There he aimed at the advancing Japs and met them with

deadly fire. There were thirteen of them, and he killed them all. He lay concealed in the fox hole throughout the night, holding the gun with his trembling hands.

At dawn he noticed four Japs approaching. They were looting the dead. He opened fire once more and killed them, too. He then climbed out of the fox hole, trembling violently, and began to run toward his own lines. He was caught on the way among the bursting shells of American artillery. He ran on until he suddenly stumbled against a protruding twig and fell. He remembered nothing of what happened further until he awoke in the hospital. He continued to tremble and felt greatly depressed. He did not improve and after a few weeks was evacuated to the States.

This patient told his story calmly and in an unassuming manner. He reiterated his desire to return to combat. Though his hands were still somewhat tremulous and clammy, he claimed that he was no longer nervous. He stated that he could not think of quitting while his brother and his friends continued fighting. He added that he considered it below his dignity to be reclassified and placed on limited duty.

It was apparent from the many comments that this soldier's story stirred every one deeply. The presence of such patients constitutes an invaluable aid in our attempt to raise the morale of the group.

During the next two sessions, the symptoms of each individual patient are elicited. Most of these symptoms reflect an underlying sense of anxiety. The patients complain of palpitation of the heart, nightmares, headaches, irritability, and intolerance to noise. Some of them are markedly depressed. They exhibit gross tremor of the hands and excessive sweating of the palms. Many of them complain of gastrointestinal dysfunction and a few display functional palsies. Some of the patients are perturbed, convinced that they are very ill. Others, especially those with hysterical symptoms, view their illness with comparative equanimity. Many patients express their indignation at having been called, at one time or another, "goldbrickers," cowards, and yellow. The very thought of returning to combat, however, throws these men into a panic. A few patients, convinced that they will be discharged from the army, are preoccupied with the fact that they have failed. They worry over what they will tell their friends and relatives when they return home with their bodies intact.

In discussing their symptoms with the patients, emphasis is placed on the functional nature of the symptoms, and the various complaints are reduced to a common source. A very elementary discussion of the anatomy and physiology of

the central nervous system is conducted in the simplest terms. The discussion is aided by a simple diagram illustrating the correlation of the nervous system with the viscera, glands, and emotions and their reaction to various changes in the environment. The concepts of the unconscious, the instinct of self-preservation, the social drive, and the conditioned reflex are formulated. The conflict between the sense of duty and the desire to escape danger and death is discussed. The nervous symptoms are explained as manifestations of intense fear in the presence of great danger. The patients are reassured that with the disappearance of the danger, the symptoms, too, will invariably, though gradually, disappear.

The patients' questions reveal an interest in the discussions and reflect a definite desire to absorb and assimilate the elicited information. Often painstakingly and on their own accord they repeat the explanations as if to make sure they have grasped them clearly.

During the remaining sessions an attempt is made to build up the morale of the patients—that is, to cultivate in them a sense of social responsibility. The importance of the attitude of each individual in molding the morale of the group is stressed. The discussions center around the war, its causes and aims. The rôle of the individual within the democracies is evaluated and compared with that in Nazi-dominated countries. Accounts of the terrific plight of the various subjugated nations are read. The tragedies that might befall our own families, should we lose the war, are evaluated. Newspapers as well as news maps are utilized as aids in these discussions. The patients are urged to evaluate critically their combat experiences. Constructive suggestions are elicited. An attempt is made to have the patients feel that during these sessions they are still participating in the common effort of winning the war.

CONCLUSIONS

Until very recently a quantitative means of evaluating the results of our treatment could not be employed, in as much as most of the psychoneurotic soldiers were not fit for full duty, and were being discharged from the army. Since War Department Circular 293 was issued, however, allowing

greater utilization in the army of the less adaptable and maladjusted soldiers, 85 per cent of the group treated have been returned to duty.

The qualitative effects of the treatment upon our patients have been definitely impressive. Their attitude of suspicion, hostility, and reserve has disappeared. Their tension has diminished considerably. They have become friendly and cheerful and have been less absorbed in their illness. In their many talks with us they have manifested less concern with their symptoms and greater interest in their problem of readjustment in the army.

Group psychotherapy was chosen at first as the method of treatment out of mere expediency, in as much as it rendered possible the treatment of large numbers of men. It has proved itself advantageous, however, in many other respects.

1. The patients, who have been previously reluctant to discuss their experiences, speak more freely in the presence of others.

2. Personal problems are automatically minimized and become a part of the larger group problem.

3. The patients' guilt feelings and sense of inferiority are relieved in the presence of others who reveal symptoms similar to their own.

4. The presence of other patients is of definite aid in socializing the patient by redirecting his attention from himself to the purpose common to all.

The favorable response of the patients to the comparatively brief period of treatment corroborates the opinion of many that psychoneurotic reactions arising in combat are not generally deeply rooted. They do not fundamentally represent lifelong problems, but rather symptoms of acute maladjustment to intolerable situations. Our studies and results lead us to believe that if these patients were treated promptly, reclassified, and placed in noncombat units immediately after the onset of their symptoms, the majority of them would continue to perform a useful function in the army. They would then return to civilian life at the end of the national emergency not as invalids, but as healthy individuals who have actually done their share to the best of their ability.

PSYCHOLOGICAL TRAINING AND ORIENTATION OF SOLDIERS

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THE mental-hygiene program of the Anti-Aircraft Replacement Training Center, Camp Callan, California, was inaugurated by the writer in June of 1942. It was necessary to begin from scratch.

As late as April, 1942, there were no psychiatrists on duty at this typical camp, where thousands of recruits, from all walks of life and from all sections of the country, were given their basic training. It was necessary to establish a psychiatric ward and a neuropsychiatric out-patient clinic in order to prevent the unnecessary hospitalization of men who heretofore had been sent directly into the hospital by medical officers of the dispensaries. The ward was opened and a proposal for a neuropsychiatric clinic was submitted to the commanding officer. It was approved and the out-patient clinic was also established.

Almost at once, it became apparent that of the great number of men who had difficulty in adjusting to army life and who were being referred to the clinic, a large number, perhaps almost the majority, were men who were experiencing varying degrees of fear, with its resultant disturbances. Perhaps of equal importance was the astounding revelation that although we were at war, great numbers of the soldiers had no idea why we were fighting, others had rather distorted ideas as to the background of the war, while still others quite obviously had been victimized by Axis propaganda long before they were inducted.

The jolt came when we realized that an annoyingly high percentage of the newly inducted soldiers would willingly

[1] On August 9, 1944, the name of the Morale Services Division was changed to the Information and Education Division.

return home within a few days after their arrival in camp, were such a thing possible! Worse yet, this same attitude was characteristic of men who were well along in training or who had already completed their basic training! This highly undesirable mental attitude toward military duty was not unique and characteristic only of our own replacement training center. From personal observation and discussions with psychiatrists and soldiers in other military installations, it was apparent that the problem was widespread throughout the army. Nor was it difficult to find the cause for this lack of enthusiasm among these recent inductees. The problem of homesickness was hardly a problem at all; and it was found in but a relatively low percentage of cases. Soldier complaints about personal inconveniences and difficulties in submitting to new "rules and regulations," while frequent, were, nevertheless, but outer manifestations of something much deeper. Nor was this underlying factor fear alone! Beyond question, the most outstanding and most frequent finding was the complete failure on the part of the soldier to personalize the issues of the war, to realize the personal stake that he had in the war, to experience a social consciousness effective enough to motivate him to act.

In addition to this failure of understanding, there was often considerable evidence of confused thinking regarding the issues of the war. Many soldiers openly expressed their willingness to fight if they could but believe "that it is not 1914–1918 all over again"! Still others found it difficult to believe that we Americans necessarily had a stake in the war; but felt rather that we had been unfortunately forced into the fight to the ultimate advantage of "Imperialist Britain" or "Communist Russia." Still others, particularly those on the West Coast, asked why we fight to save China when "the hordes of China represent the yellow peril"!

The source of this confused and warped thinking was not difficult to find. Most of it sprang from a miserable neglect and failure on the part of parents and teachers and other channels of opinion formation to assist the young men of our country to understand the true nature of things and the relationship between our country and the rest of the world. Twenty years of misguided cynicism, pessimism, and sterile

isolationism did not suddenly disappear with the announcement of Jap bombs on Pearl Harbor.[1]

It was clear that it was not sufficient that the psychiatrist detect and remove from the service the already neuropsychiatric misfit, but that he had another responsibility—namely, to assist the soldier in understanding *why* he was fighting in order that he might become an effective fighting man and, from the point of view of mental hygiene, might be armed against the development of any serious personality disorders. That such a soldier would be a better citizen after the war was obvious.

Elsewhere[2] we have described a step-by-step procedure for detecting the neuropsychiatric misfits (psychotics, neurotics, pathological alcoholics, psychopathic personalities, mental defectives, and so on); in addition, we made the following statements:

> "No mention has been made so far of the positive, preventive aspects of military psychiatry. So far, we have discussed only the actual neuropsychiatric misfit, or the person who is so peculiarly constituted that he represents an almost certain neuropsychiatric casualty.
>
> "It must be clearly understood that under sufficient stress and strain any man may break down. A broad program of preventing neuropsychiatric casualties embraces a definite procedure, which we can only touch on in this report. Suffice it to say that adequate rest and provision for recreation are both fundamentally important. Meaningless petty restrictions contribute nothing of constructive value and definitely tend to undermine morale. And speaking of morale, it is perhaps not out of the way to suggest that morale is not something that springs from dances, movies, and radio programs alone. While such things are indeed a necessary part of the recreation which must be provided for the men in the armed forces, morale in itself is something of a much more fundamental nature.
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> "High morale springs from a full knowledge of the meaning and the significance of this war. It enables an individual or masses of individuals to carry on and persevere in their mission in spite of adverse conditions, disheartening developments, defeatist rumors, fatigue, hunger, and physical discomforts. It is a state of mind which can come to a soldier only when special pains are taken to instruct him in the fundamental issues at hand—to make him feel that he is an integral part of everything his nation is fighting for—to arouse in

[1] See "Square Pegs in Fox Holes," by Julius Schreiber. *Beacon*, Bulletin of Mental Hygiene Society of Northern California, Vol. 2, No. 3, September–October, 1943.

[2] See "A Neuropsychiatric Program for a Replacement Training Center," by L. E. Stilwell and Julius Schreiber. *War Medicine*, Vol. 3, pp. 20–29, January, 1943.

him a social consciousness the like of which he has never felt before. This most necessary condition can be achieved only through a systematic program of education. Men who are imbued with a zeal which springs from a full knowledge of what they are fighting for are less apt to experience emotional or other personality disorders as a result of actual warfare.

"The trainees are but recently drawn from civilian life. Many have for years been subjected to enemy propaganda (often concealed under the cloak of 'patriotism'), constructed with the deliberate intent of creating disunity, defeatism, confusion, and undemocratic and distorted views. The fact that this nation has been at war with the Axis for nearly a year has not by any means clarified the thinking of many trainees, as any psychiatrist dealing with such men at a replacement training center can attest. Since the trainee is in the center but a relatively few weeks and is then sent to a tactical unit, it would seem to be imperative that some program of education be vigorously carried out during the training period. The two best approaches while the trainee is here at camp lie in the camp newspaper and in the lecture halls. It would be a grave mistake to dismiss lightly this phase of military psychiatry by mere passive agreement. It is of the utmost importance that the camp newspaper carry the proper type of material, presented in a fashion that is easily understood, and that the orientation talks given to the soldiers cover the necessary subject matter thoroughly and are presented effectively."

To meet this problem it was necessary, during the brief few weeks of training, to attempt to neutralize, if not actually to remove, a great deal of accumulated misinformation; to clarify where confusion previously existed; and to encourage the understanding few to help their fellow soldiers in their problem of knowing why they had been called upon to fight.

PSYCHIATRIC ORIENTATION COURSES

Our first approach was to give a series of classes to officers and noncommissioned officers, acquainting them with the high lights of psychiatry, so that they might know what to look for in their men. In addition, we reviewed with them the background and issues of the war in order that they might "talk it up" with their trainees.

Officers, noncommissioned officers, and social workers were taught the high lights and symptomatology of neuropsychiatric disorders. The importance of neuropsychiatry in general, and for a military program in particular, was properly emphasized. There were six lectures in each series, and there were three series a year. Thus, there was reasonable assurance that officers and noncommissioned officers would be "kept on their toes" and that newly assigned officers and

noncommissioned officers also would be reached. Attendance was compulsory for noncommissioned officers and social workers, but was optional for officers. (When deemed advisable, an occasional compulsory lecture for officers was ordered by the commanding general.) The subject matter was presented in layman terminology, although some effort was made to acquaint the students with psychiatric terminology. The material presented in these lectures may be outlined briefly as follows:

A. *Background of military psychiatry:* Economic and social problems arising from neuropsychiatric casualties. The responsibilities of officers and noncommissioned officers for bringing potential neuropsychiatric casualties to the attention of the psychiatrist. The disposition of various neuropsychiatric cases. General symptomatology of the psychoses.

B. and C. *The psychopathic personalities:* General symptomatology manifested by the schizoid, the cycloid, the antisocial, the paranoid, and the epileptoid personality, the pathological alcoholic, the drug addict, and the sexual psychopath.

D. *Neuroses:* General description of subgroups. Psychological and physiological principles involved in the formation of symptoms. The difficulty these men experience in attempting to adjust to army life.

E. *The mentally deficient:* Definition of term. Description of various tests employed to establish the existence of mental deficiency. The potential work level and military value of the mentally defective. The purpose of the special training battery.

F. *General problems of army adjustment:* A review of the changes in circumstances of living following induction into the army. Fear—its meaning, the havoc wrought when it is out of control, and its counteraction. The principles of leadership. The purpose of discipline and its attainment. The judicious use of recreational facilities. The fostering and development of correct mental attitudes toward the war.

This first concrete step was fruitful, but far from enough. Nevertheless, it was several months before we launched our next activity—a weekly column that we wrote for the camp newspaper. This column was always entitled *Unconditional Surrender!* and was kept anonymous. We attempted to write in so-called "G.I." or soldier language. Because of direct contacts with the trainees, noncoms, and officers, we were always able to use the column to answer specific issues that came up in camp life or in the thinking and discussions of the men during the previous week. The following is a typical column:

"I was killed this morning!

"Yes, I died this morning—and it was my own fault. It was a stupid, useless, and meaningless death. You see, I died before I even

got a shot at the enemy. I died because I neglected a fundamental principle that I should have mastered while I was in training.

"In those last few minutes of life—in that brief interval after I was hit—a lot of things raced through my mind: my early childhood, my school days, my friends, my dad, my mother, my kid sister. Yes, I even remembered the dreams that I had had for my future—the good job, the nice home—all the comforts and security a man could ask for.

"But that's not what I want to tell you. I want to tell you how it happened that I got killed. It's all over with me—but you guys in training—you've still got time. Listen—

"I guess one of my first sins was that of 'knowing too much' for my instructors. Sure, I attended lectures and demonstrations. I was there in the flesh, but my mind was millions of miles away.

" 'Are you listening, Smith?' Cpl. Hodge used to ask.

" 'Sure, I'm listening!' I used to say, but my mind was still on that girl down in San Diego. You'd think I'd have known better—you'd think I'd have realized that I should be learning everything about the business—but, no—not me! I was still the school kid trying to outsmart the teacher!

"Yes, and I had my share of AWOL! 'Away on Love,' we used to call it. That, too, was the wise guy in me. I remember the first time—I was green and I knew I was going to be late for bed check.

" 'Aw, let's go up to Los Angeles. We're late anyhow—might as well be twenty-four hours late!' This from my pal, Eddie, who was later to be discharged on a Section VIII. As I said, I was green and I hadn't yet learned that Hitler and Tojo want all the Yanks to go AWOL and as often as possible. My mind was too befogged with the liquor I had been drinking and I couldn't begin to appreciate the fact that being AWOL was harming no one but myself. It was again a case of trying to put something over on the teacher!

"And then, you know, even on the way over here I noticed that there was something different—most of the guys seemed to be all steamed up and raring to get at the enemy. But me—no, not me! In a vague sort of way, I knew that we had to lick the Axis, but somehow I don't think I ever really learned what they used to call the 'issues of the war.' Know why? Yes, you guessed it. I used to think it was all a lot of hooey. Reading the papers and listening to guys talk about what we were fighting for used to give me a pain in the neck. 'It's all a lot of propaganda,' I used to say. You know I even used to sleep during the orientation lectures and movies. Fact is, I used to look forward to that hour in the theater because it meant another hour when I got out of training and had a chance to sleep.

"And talk about goldbricking—that was my long suit! Poor Sgt. Johnson!

" 'Smith!' he used to yell. 'Don't tell me you're sick again!'

"And with an innocent and injured look, I would tell him that my back was aching again or that my stomach was on the blink or that my feet were giving out and I just couldn't make the hike. And when I'd get up to the dispensary, it was the same battle all over again. I put it over on the medical officer the first couple of times, but from then on, I had to resort to every trick in the bag! Yep, I was the

bright guy—always figuring how to get out of things! You know, it seemed funny then, and there were actually some guys in the battery who thought I was pretty clever. And so did I. Tojo must have been very pleased because I was getting ready to die and I didn't know it.

"If only I had been wounded! If only I had a chance to live and to do the thing right. There's Harris lying there—he got hit in the leg and in no time he'll be patched up and ready to go at it again. Good old Harris! He got hit in the leg trying to come to my rescue! Many is the night when I used to think there was something wrong with that guy—I could never persuade him to go down to San Diego with me.

"'Come on, Harris—let's go to town,' I used to say. 'I know a couple of gorgeous babes!' And always his reply was the same: 'No, Joe, not to-night. I've got work to do.'

"Work! Work! Work! Some guys always seemed to work. Suckers! I used to think. What'll it get you? And when some of them became officers, I could only think that they had gotten a lucky break.

"Well, this morning we went Jap hunting. At first we were all scared. We hadn't been up before. And then things began to happen fast. Jap machine gun to the right—it was like a scene in a movie—every one seemed to know what to do—that is, every one but me. I stood there—yes, STOOD there trying to figure it out. That's when I got that hot lead over my heart! 'Fall flat and hug the dirt!' the corporal used to say back in training camp. 'Discipline yourself to instantaneous action!!!' I could still hear his voice, even though it was now faint and weak.

"All those years of growing up—all those years at school—all those weeks in training camp—all shot to hell—all blasted to nothing. Why? Because I knew all the answers—I was the wise guy who wouldn't listen because no one could tell me anything! I am a failure—a fatal failure—at twenty-one!"

At the same time that we began the newspaper column, we also requested and were granted the opportunity to use the daily news casts (over the camp loud-speaker system) as a channel for mental-hygiene talks and counter-propaganda. This proved to be a most successful and effective weapon.

Also at about this time, we began to give one-hour mental-hygiene talks to each new battery (250 men) as it was activated in the camp.

In these talks, rapport was easily established by our frank admission to the men that we were aware of their difficulties; that we understood that many had given up lucrative jobs, that many had had their studies at school interrupted, that they had been separated from their wives or families, and so

on. In all talks with the soldiers, as in all of our relationships with the men, the cardinal rule was to be honest and sincere. The language used was that which the men themselves use. We never "talked down" to them. The following is an outline of the mental-hygiene talk:

A. *Changes in circumstances of living following induction into the army:* Separation from family. Curtailment of previous luxuries and pleasures. Economic changes. Interruption of studies. Separation from job or profession. Loss of civilian individuality and submission to new form of discipline. Numerous and, at times, perplexing "rules and regulations." Assumption of increased responsibility. Total situation wherein the demands of war constantly conflict with soldier's innate and acquired drives.

B. *Five aspects of an ideal soldier:* 1. Expert in the use of his weapons and other aspects of military training. 2. Physically fit. 3. Thoroughly disciplined. 4. Conditioned for combat situations. 5. A zealous conviction of the righteousness of his cause deriving from a full understanding of the war issues.

C. *Definition of terms: morale—democracy—fascism.* 1. *Morale:* Morale is a state of mind that enables a soldier or civilian or millions of such people to carry on and persevere in their missions in spite of the most adverse conditions, disheartening developments, defeatist rumors, fatigue, hunger, great physical discomforts, and even the threat of actual death. High morale springs from a full knowledge of the meaning and significance of this war. It is a state of mind that can come to an individual only when he fully understands the very fundamental issues at hand—only when he feels that he is an integral part of everything that he is fighting for—only when there has been aroused in him a social consciousness the like of which he has never felt before.

2. *Democracy:* Democracy, simply stated, is a form of society wherein government rests with the majority of the people. There is no better definition for it than that expressed by Lincoln—a "government of the people, by the people, and for the people." It would be wrong and useless to say that the implications and full development of democracy have been reached in our country. However, it is our job to see that the issues of the war are so personalized in the mind of each soldier that he is fully conscious of his own stake in the world for which we are fighting. The terms, "political democracy," "social democracy," and "economic democracy" are not empty phrases. They are inherent in our very form of government and represent fundamental objectives for which not only we Americans, but all of the Allies are fighting.

3. *Fascism:* Fascism is a political, social, and economic form of society wherein by virtue of a merger which has been accomplished between certain powerful financial interests and a military machine, the entire nation is under the dictatorship of this oligarchy. Individuality and freedom are suppressed "in the interests of the state," which happens to be none other than the dictating oligarchy. Since so radical a change in a form of government is not very easily accomplished, the transition to fascism is, at first, made easier by demagogic

political agitation of the kind which is described as "We are all things to all men." To gain the backing of powerful industrialists, whom Vice-President Wallace described as wishing "to change the sign-posts and lure the people back into slavery," a form of society is offered that will protect their interests; to the middle and working classes, liberal phrases are demagogically mouthed; to facilitate the accomplishment of their objective, disunity is created by playing political groups against each other, religious groups against each other, social and economic groups against each other. A confused and disunited people can offer no effective resistance to the seizure of power by this newly merged oligarchy.

D. *Recognition of enemy propaganda:* The soldier is forcibly reminded that the enemy is fighting him on the psychological front with the same deadly earnestness as it does with planes and tanks.

1. *Disunity rumors, internationally:* Propaganda intended to create disunity between the allies: anti-British, anti-Russian, anti-Chinese, and so on.

2. *Disunity rumors, nationally:* Propaganda intended to revive and fan the flames of old hatreds, prejudices, and suspicions such as anti-Semitism, anti-Catholicism, anti-Negro, anti-Capital, anti-Labor, and so on.

3. *Defeatist rumors:* Propaganda calculated to demoralize both soldier and civilian by destroying his faith in our military leadership, in our military equipment, in our national leadership; to prepare us to become overwhelmed by enemy threats such as, "The worst is yet to come. This is but the beginning"; to prepare the groundwork for the "It is no use! All is lost" state of mind.

4. *Narcotic rumors:* Propaganda intended to lull us into smug complacency; to keep alive the "business as usual—vacation as usual," suicidal frame of mind; to get us to believe that the enemy is falling apart of its own weight—that we may now relax our efforts!

5. *Peace offensive:* A revival of the Munich Program of "Peace at any price." Our President, our Vice-President—all of our responsible leaders have said that there cannot be a peace until fascism is utterly and completely destroyed! Any premature attempt at peace is to betray us into the hands of Hitler! The order reads "UNCONDITIONAL SURRENDER!"

6. *Pro-fascist propaganda:* While all of the above five types of propaganda rumors must, of necessity, be demagogic in nature, there is still a direct pro-fascist propaganda directed toward those elements within each country of the Allied Nations who have always been ideologically fascist, have not given up their views, or, at most, have wavered a bit since the war began. Such propaganda is directed to them in order to bolster those who may waver as well as to give directional leads for the active enemy agents within each allied nation.

E. *Analysis and discussion of some factors that prevent a satisfactory adjustment to military life:* Inadequate understanding of the meaning and purpose of discipline. Fear—its meaning; psychological and physiological disturbances that result when it gets out of control; methods of dissipating fear. Alcoholism. The goldbricker. AWOL. Asocial individuals. Antisocial personalities.

F. *Conclusion:* The soldier is presented with the following thesis:

> The more profoundly we understand and hate the curse of fascism, the more deeply we appreciate democracy and its promise for humanity, the more alert we are to detect and combat enemy propaganda, the more thoroughly we train, the more physically fit we become, the more we submerge our personal problems to that of the great problem of winning the war—that much more certain are we to go through this war without the development of any serious mental illness, and that much greater is our personal contribution to winning the war.

Within thirty days after launching the column and the interpretation of the daily news, we began our weekly current-events forum. Attendance at these forums was on a voluntary basis, and to this forum—held one evening a week, from 8 to 10 P.M.—usually came the so-called "opinion-forming" men in the camp. These men were very much alive, and the forums were always a source of stimulation, clarification, and general education.

The attendance at the forum varied; a fair average, however, was approximately 75 soldiers. There was, in addition, a sprinkling of officers, nurses, social workers, and a few of the civilians who were employed at the post. The important point was the fact that the soldiers who came to the forum were leaders in their platoons or batteries. They were the ones who "set the pace," as it were, in the bull sessions and general discussions that go on among the men. The value of having such soldiers together every week for a broad general airing of views is obvious.

Next, we launched a permanent series of classes in citizenship and war issues, given on a compulsory basis to each of the batteries. The classes were held on a lecture-discussion basis and the period was one hour per class. The subjects covered are outlined below:

> A. *Democracy:* 1. Review of the concept and growth of democratic institutions. 2. The achievements of democracy. 3. Obstacles that democracy had to surmount. 4. Obstacles that democracy has yet to surmount.
>
> B. *Fascism:* 1. Definition. 2. Factors that make for its development. 3. Manifestations of fascism from origin to maturity. 4. Inevitability of the clash between democracy and fascism.
>
> C. *World interdependence:* 1. The strategic, economic, and political implications of geography. 2. The interdependence of the world.
>
> D. *National and foreign policies of the nations at war:* 1. Major issues of conflict among nations of the world from 1918 to 1939. 2. A consideration of the national and international factors which determine the foreign policies of the nations. 3. The common interests of the Allied Nations.

E. *Post-war problems:* 1. Axis ideas for a post-war world. 2. War aims of United Nations. 3. Ideas on post-war reconstruction emanating from the United Nations. 4. Can world coöperation actually be achieved?

Further to stimulate the thinking of the men, we inaugurated "radio editorials." These were short, 200-to-300 word editorials on camp-life problems, war issues, war aims, and so on, written by the trainees in the camp. The best one submitted for that given day was read over the camp loud-speaker system during the regular news-cast period, with full credit given to the trainee who submitted the editorial.

The small staff that we had underwent intensive training in our clinic. They were taught some of the more fundamental principles of psychiatry and were able to "write-up" good psychiatric histories on all problem cases referred to the clinic. In addition, they were excellently equipped to assist the maladjusted soldiers upon an individual-psychotherapy basis. Much more important, however, was the fact that these same people participated in the much broader program of "preventing problems." Our self-assigned task was to reach every soldier in camp.

OBJECTIVES AND PRINCIPLES

In every phase of our work, whether it was upon an individual-treatment basis in the clinic or upon a mass basis through the weekly newspaper column, the daily news cast, the citizenship classes, the current-events forum, the mental-hygiene talks, the lectures to officers and noncoms, and so on, the entire staff was guided by definite underlying principles:

A. The tremendous value of our program is threefold: the soldier who fully understands his personal stake in the war, who fully understands the meaning and significance of democracy, and clearly knows what fascism is and what would happen to him, his family, and his country, should we lose the war, will, unless he is mentally ill, have the highest degree of *morale* and will develop an intense and consuming *hatred* for the enemy's military and political machines and what they stand for. This mental attitude will of necessity (1) make him train seriously and be determined to annihilate the enemy; (2) contribute greatly to the prevention of uncontrolled fear, panic, and serious mental illness; (3) make of him a finer and better citizen in the democracy for which we are fighting after the war is over.

B. While the job of making the soldier an expert in the use of his weapons, physically fit, mentally conditioned for combat, and a thor-

oughly disciplined member of his unit belonged to the line officers, the problem of furnishing the soldier with *morale*, of giving him the dynamic spirit, the drive, and the *will to fight* was our specific assignment. Therefore, it goes without saying that every member of our staff was not only fully informed on the background of the war, the issues for which we fight, and current events, but, further, he had the capacity to radiate and instill in the soldiers a passionate love for democracy, a fierce and intense hatred for fascism, and a zealous determination to destroy the enemy.

C. In everything that was said or written, the staff was guided by six fundamental base lines: (1) Allied unity; (2) national unity; (3) anti-defeatism; (4) anti-complacency; (5) anti-peace offensives (as opposed to unconditional surrender); and finally (6) anti-outright-fascist propaganda. These six base lines are fundamental guides and every member of the staff was on the alert to detect enemy propaganda, against any of these points.[1] Over and over again, through every channel at our command, the soldiers were acquainted with these base lines, and innumerable examples of everyday current events were used to illustrate how the enemy attempted to "sabotage their thinking" through his various propaganda tricks. In this manner, the entire background of the war, the issues for which we fight, and current events were forcefully kept alive. Through every channel possible—the press, the lecture hall, the movies, and the loud-speaker system—we did not permit the soldier to experience a prolonged emotional or intellectual lag. News maps were prominently displayed in recreation halls and other areas of congregation and very large maps were used in battalion areas during the daily news cast in order that one of the battery officers might point out the various geographical areas that were under discussion as the news came over the loud speaker.

EVALUATION OF THE WORK

It is quite correct to say that the overwhelming majority of the men changed their attitudes as the weeks in training went by. We believe this change in attitude is directly attributable to the program that we conducted. From comments made to us by the officers and noncommissioned officers as well as the trainees themselves, we knew that good work was being done, although, as always, there was constant need for improvement and expansion.

As the program unfolded, we received favorable comments and letters from psychiatrists and laymen alike, both in military and civilian life. A few psychiatrists, however, questioned the "value" of such work. Some, understandably, demanded "proof" that the program achieved what it set out to accomplish. Others questioned the premise that there was necessarily a direct connection between a high state of

[1] See "Morale Aspects of Military Mental Hygiene," by Julius Schreiber. *Diseases of the Nervous System*, Vol. 4, pp. 197–201, July, 1943.

morale and a low incidence of neuropsychiatric disorders. Some even expressed the rather odd belief that a psychiatrist "has no business talking about things beyond the human body or the individual's emotional and intellectual experiences"! It was suggested by one colleague that "soldiers would look down or laugh at a psychiatrist if he tried to talk to them about such things as why we are fighting, or democracy, or such other abstractions"!

Certainly, no one would question the wisdom of General Sir Bernard Montgomery, commander of the British Eighth Army. This is what General Montgomery has to say about morale:

> "The big battle-winning factor is morale, and the side whose troops possess the higher morale will win, other things being equal. . . . The morale of the soldiers in the Eighth Army is quite amazing. It is so terrific as to be almost dangerous. They look upon themselves as an invincible army that can do nothing wrong.
>
> "That morale has showed itself in a marked way in the sickness rate. I would not be bothered if my sickness rate was two men per thousand per day, and I would say that that is a low average sickness rate. But the sickness rate in the Eighth Army during the North African campaign was never higher than 0.5 per thousand per day. That was one man per thousand evacuated to hospital every other day. It is an amazing record, and it is all connected with the matter of morale."[1]

Again, in a paper read before the American Psychiatric Association in May, 1942, Drs. Edward A. Strecker and Kenneth E. Appel said:

> "In our own country, morale-making efforts in army and civilian life have been somewhat feeble. Citizens of a democracy are willing to pay for the precious boon of unfettered thought and speech with its inevitable penalty of some lack of national harmony. However, it should not be necessary to pay through the nose.
>
> "Psychiatrists are rightfully entitled to recognition as experts in morale. Our attention is constantly focused upon human personality, including not only the endowments brought into the world by each individual, but the total of the entwined somatic and emotional experiences of life. Morale is the spirit of personality . . . .
>
> "Morale does not grow on trees. It must be made. It can be made by propaganda and it can be broken by propaganda . . . .
>
> "Psychiatrists are not making, we believe, the contributions they can make to the general morale. They have not been active enough in making known the contributions they can make. The government is not aware

[1] From a speech by Sir Bernard Montgomery condensed and reprinted in *Britain* (publication of the British Information Services), Vol. 2, No. 6, October, 1943.

of the contributions psychiatry can make in the field of ideology, aggression, fear, war propaganda, and morale. Psychiatrists have more knowledge of anger, fear, and the influence of ideas on people than any other group in the community. Psychiatry has been thought of chiefly as concerned with the study and treatment of the individual, not as having contributions to make to society as a whole. Psychiatry has a tremendous power to contribute to social forces beyond the clinical frontiers . . . .

"Psychiatrists attain some understanding of the human psyche. In miniature the mind of man is the state with its imperfections and debasements; its aspirations and ideals; its assets and liabilities; its conflicts. Psychiatrists are equipped and obligated to do all they can in the making of winning morale."[1]

Colonel Franklin G. Ebaugh says:

"In the Replacement Training Centers we have a great opportunity for excellent preventive mental-hygiene work, besides our obvious duty to eliminate the unstable that have not been rejected by the induction centers . . . . This psychological toughening and education of troops is a very important phase of the work."[2]

L. R. Sillman wrote, in *War Medicine,* that "Bermann, who served with Loyalist Spanish Forces, has pointed out that soldiers who entered the Loyalist cause out of conviction suffered much less from war neuroses than those who were drafted into the army and had no political convictions about the war."[3]

The Englishman, Maxwell Jones, writing about British troops, has this to say:

"The majority of patients seen here have a very circumscribed outlook and are largely preoccupied with their own symptoms, emotional difficulties, and domestic situation; few have reflected on the reason for their conscription or have stopped to consider what they are fighting for. They seldom read newspapers and have only the vaguest conception of the extent and complexity of the war. To them there exist their home and a vague, ill-defined, unfriendly outside world. With no better sense of values than these it is not surprising that some men quite openly and shamelessly hope for nothing but their discharge from the Army."[4]

Another Englishman, W. Ronald D. Fairbairn wrote:

"That even the 'normal' soldier may develop a war neurosis, albeit a transient one, in circumstances in which morale becomes impaired

[1] See "Morale," by Edward A. Strecker and Kenneth E. Appel. *American Journal of Psychiatry,* Vol. 99, pp. 159–63, September, 1942.

[2] See "Misfits in the Military Service," by Franklin G. Ebaugh. *Diseases of the Nervous System,* Vol. 4, pp. 293–98, October, 1943.

[3] See "Morale," by L. R. Sillman. *War Medicine,* Vol. 3, p. 498–502, May, 1943.

[4] See "Group Psychotherapy," by Maxwell Jones. *British Medical Journal,* pp. 276–78, September 5, 1942.

> can leave us in no doubt regarding the intimate connection of the question of morale and the question of the war neuroses. This phenomenon also serves to show that some measure of infantile dependence may be revealed even in the case of the most 'normal' individual—the fact being that emotional maturity is never absolute, but always a matter of degree. In the light of what happens when an army collapses in the field we are further entitled to draw the conclusion that, whilst any high degree of infantile dependence is in itself inimical to morale, the existence of a high state of morale within a group can exercise a profound influence in counteracting the ill effects of infantile dependence among its members. In conformity with this view it has been strongly maintained by well-informed military opinion that during the war of 1914–18 the incidence of war neurosis varied between units in inverse proportion to their morale; and this opinion would appear to be capable of statistical verification even when allowance is made for the idiosyncrasies of regimental medical officers. The incidence of the war neuroses in an army may thus be regarded as a criterion of morale . . . .
>
> "Perhaps it is small wonder, too, that, after acquiring some disillusioning experience of neurotic service men en masse, I was driven to remark, 'What these people really need is not a psychotherapist, but an evangelist.' In the light of further experience I see no reason to think that this remark was greatly in error; for I remain convinced that, from the national standpoint and from the standpoint of military efficiency, the problem presented by the war neuroses is not one of psychotherapy, but one of morale."[1]

One might go on and cite more and more such expressions of opinion—if it were really necessary. We *know* that the mental-hygiene program that we conduct is sound and effective. Our whole thesis has been simply this: If we can do anything to clarify the confusion in the thinking of those soldiers who come into the service with many conflicting and disturbing views regarding the war in general and particularly as it relates to them; if we can help men who believe that the war is unjust, that it was instigated by Wall Street or by the Catholics or by the Jews or by the Communists or by the British or what have you—if we can help these men to see the error in their thinking; if we can help men who are experiencing uncontrolled and severely disturbing fear reactions by having them so personalize the issues of the war that their fears are replaced by a wholesome, consuming hatred for the enemy and everything he stands for; if we can take men who are having difficulties in adjusting to camp life because of separation from their home, because they gave up jobs with good salaries, because they had their studies

[1] See "The War Neuroses: Their Nature and Significance," by W. R. D. Fairbairn. *British Medical Journal*, pp. 183–86, February 13, 1943.

interrupted, because they have difficulty in accepting new rules and regulations—if we can take these men and lead them by orientation in war issues and war aims to submerge their personal problems to the big problem of winning the war—if we can do all this, we told ourselves, then we are indeed doing good mental hygiene.

That was the task that we set out to do and we are certain that we achieved this with remarkable success. Our soldiers trained better; the majority left the camp with a determined conviction that the enemy must be destroyed; and the incidence of neuropsychiatric disorders was considerably reduced.[1]

THE ARMY ORIENTATION COURSE

While the mental-hygiene program described in the preceding pages was independently conceived and developed by the author, it must be pointed out that the War Department had already recognized the need for orientation of troops. The recognition of this logical need was, of course, to be expected. What is surprising, however, is the fact that *laymen,* rather than psychiatrists, were responsible for the inauguration and development of what is now known as the Army Orientation Course. Even before Pearl Harbor, it was recognized that the American citizen-soldier should be given some understanding as to the reasons for his being in uniform. At that time, under the auspices of the Bureau of Public Relations, a series of fifteen lectures was prepared and distributed throughout the army for presentation to the troops. In addition, a number of civilian lecturers toured the camps of the country. In general, it was found that these facilities were insufficient to meet the whole objective.

Early in 1943 the Army Orientation Course was transferred from the Bureau of Public Relations to the Special Service Division. Several months later, the Special Service Division was reorganized and Major General Frederick H. Osborn, then Director of the Special Service Division, became the

[1] The author is preparing an analysis of the psychiatric material seen by him during two contrasting periods of eight months each. This study will show a reduction of 35.2 per cent in the neuropsychiatric cases seen by him during the second eight-month period—a drop, that, after the cancellation of all extraneous factors, he attributes to the mental-hygiene program described.

head of the newly formed Morale Services Division. In this reorganization, the Army Orientation Course, together with other activities (education, information, research, and so on) came under the jurisdiction of the Morale Services Division.

It was the author's good fortune to be assigned to this newly formed Morale Services Division at its very inception. He has witnessed the amazing spectacle of laymen performing a most outstanding achievement in the field of mental-hygiene. A school for the special training of orientation officers was established in October of 1943. To this school are sent officers (nonmedical) who have a good background in the political, social, and economic factors that led to the outbreak of the war; men who have deep personal convictions in the righteousness of our cause; men who have expressed an eagerness to carry out the mission and who have ability to transmit their knowledge and enthusiasm to the troops, in the common, everyday language of the soldiers.

In addition, there is a wealth of material produced by the Orientation Branch of our division. This material covers basic, fundamental concepts, as well as analyses of current military and diplomatic developments. It is written at such a level that it is at once easily understood by officers and soldiers alike.

The over-all objectives of the Army Orientation Course may be summarized under six broad categories: (1) Know Why We Fight, (2) Know Our Allies, (3) Know Our Enemies, (4) Know the News and Its Significance, (5) Know and Have Pride in Your Outfit and in Your Personal Mission, and (6) Have Faith in the United States and Its Future. It will readily be seen that in order to achieve these six broad objectives, it is important that the soldier be given ample opportunity to review and discuss the two conflicting ideologies: democracy and fascism. He must be given an opportunity to learn and ask questions about our allies, their social, political, and economic make-up. Likewise, he studies the enemy. He learns about enemy propaganda objectives and techniques. The importance of his arm or branch of the service is made very clear to him; and more important is his realization of the importance of his own personal mission. Each week he is given an opportunity to review and to dis-

cuss the meaning of significant military and political developments. And underlying all this type of training is the constant emphasis on what the soldier is fighting for—the world in which he is to live after the victory has been won. The rôle and his obligations as a citizen upon return to civilian status become increasingly clear to him.

Early in 1944 the author made an extended tour of the entire country. With the assistance of a junior officer and three noncommissioned officers, he set up model orientation programs in each of the country's nine service commands. More recently, the author performed a similar mission in the Central Pacific. In all of his trips to the field, he addressed thousands of officers and troops. The conclusions are inescapable: The men of our armed forces are definitely concerned with the basic questions as to how this war came about, the developments and trends of military and diplomatic events, the issues for which this war is being fought, and what they have to look forward to in the world they will live in after the victory has been won.

It is the author's sincere conviction that one of the greatest contributions to our country's future has been made possible by the vision and the courageous pioneering efforts of the staff officers of the Morale Services Division. This entire program, which has begun at the request of the Chief of Staff, General George C. Marshall, and so ably carried out under the direction of Major General Frederick H. Osborn and his staff, is without a doubt a most effective and all-embracing mental-hygiene program, and perhaps most amazing of all is the fact that with the exception of the author himself there is not a psychiatrist in the lot!

NEW CONCEPTS OF REHABILITATION*

MICHAEL J. SHORTLEY

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DURING the past twenty-five years much social legislation has been enacted throughout the world. Such legislation has not generally grown out of a definite plan for social development, but rather out of recognition that want and misery among any considerable group create a pathological condition that is inimical to the welfare of the people. Action has been impelled also by the sound tenet that a nation connot long afford to permit the existence of large groups of persons who not only do not produce, but who also consume the production of others.

This session of your conference is devoted to those measures within the general framework of conservation and social security that provide for the rehabilitation of the disabled. My part will be to outline for you the new Federal-state program under the Federal Security Agency, which was recently initiated by the Congress in passing the Vocational Rehabilitation Amendments of 1943, Public Law 113, 78th Congress; to suggest to you the broad implications of this legislation as a public service to conserve the greatest of all assets—the working usefulness of human beings; and to indicate the rehabilitation services we may now render.

First, I should like to say that we view a physical handicap as a difference possessed by some persons, which, though limiting them physically, need not limit them vocationally. Complete physical perfection is a rare thing, if not a theoretical standard which no one actually achieves. Every person has physical characteristics that limit accomplishments in certain fields, and a person's capacity to work is not the result merely of anatomical make-up. Native ability, personality, and training all contribute to productivity.

Our program, therefore, estimates the dimensions of its

* Presented at the Louisiana Conference of Social Welfare, New Orleans, April 19, 1944.

problem in terms of all handicapped persons whose employability can be improved. To state an actual figure is difficult since there are no reliable data available on the current number of disablements from all causes. It is equally difficult to be exact as to the number of those who need rehabilitation services before satisfactory employment can be possible.

A backlog of two million persons, potentially employable if rehabilitated, was revealed by the U. S. Public Health Service National Health Survey in 1935. There is a staggering normal toll, averaging eight hundred thousand persons, of injured each year, one hundred thousand being so severely disabled as to require special services to render them employable. These facts we know. Allowing for changes that have undoubtedly occurred that alter both the incidence of disablement and the total number of disabled in the population, we estimate conservatively that there are one-and-one-half million persons for whom rehabilitation is needed now.

The program, in the American way, aids the man and woman injured in industry, or by accident or illness, to maintain the human dignity of independence in productive work by a valid investment in essential services to effect their placement in remunerative employment.

You will recall that an approach to the problems of civilian disablement was first made by the Congress twenty-four years ago with the Vocational Rehabilitation Act of 1920. The Social Security Act of 1935 carried the stabilizing provision for a continuous rehabilitation service. With this legislation forty-seven of the states, the District of Columbia, Hawaii, and Puerto Rico, undertook a vocational-rehabilitation program which, though limited in funds and services, rehabilitated 210,000 persons into employment prior to July, 1943. The average cost per case was $300, a non-recurring expenditure that contrasts with the $300 to $500 required each year to maintain a dependent person at public expense. Average yearly earnings rose from $110 to $1,228 after rehabilitation.

The results of the pioneer years obviously represent a small inroad into the potential case load of handicapped

persons. They are meaningful to the disabled who were served, and in pointing up the unmet needs of the disabled in the matter both of number and of additional services that should be a part of rehabilitation. Most important, they afford a firm foundation of experience and knowledge on which to build the broader, stronger program now authorized.

The new law made no fundamental change in the principles or objectives of rehabilitation. The basic policies of state control and operation of the program, with Federal guidance for stability, uniformity, and technical assistance, are preserved.

Under provisions of the act, the mentally as well as the physically handicapped may be served; the blind may be rehabilitated on the same terms as other groups of the disabled; and there is specific provision for war-disabled civilians. The latter are defined as merchant seamen and members of the aircraft warning service, the civil air patrol, and the citizens defense corps, who are injured in line of duty.

Federal fiscal provisions are considerably liberalized in our recent act by removal of the fixed ceiling on Federal funds to carry out the program. The Federal Government is permitted to assume all necessary state administrative costs. Medical diagnosis and treatment, vocational training, and other similar services for the usual groups of handicapped persons are shared by state and Federal Governments on a fifty-fifty basis; while services for war-disabled civilians receive full Federal reimbursement.

The most significant new provision enables the use of Federal funds for the physical restoration of the handicapped so that they may as nearly as possible approximate a normal work capacity.

We have long believed that the rehabilitation axiom should be, "Never train around a disability that can be remedied." Medical authorities have long agreed that tackling the complex problem of rehabilitation without including physical restoration is putting the cart before the horse. The authority now to enlist medicine, surgery, and the auxiliary

professional specialities, along with vocational guidance and training, rounds out the vocational-rehabilitation program for a realistic attack on the problems of disablement.

Through the Federal-state coöperative administration of our program, the operation of the program rests with the state boards of vocational education—each having a bureau or division of vocational rehabilitation, with a full-time staff—and with the state agencies for the blind.

The use of existing facilities and the mobilization of resources, rather than the creation of new facilities or the attempt to equip one agency for the total job of rehabilitation, set the pattern of program organization. They indicate also the human-engineering approach toward perfecting methods of operation and achieving efficient administration.

The program establishes no special works projects. Instead, training is obtained from public and private schools, from vocational-training courses, and from in-service training on the job. No hospitals or medical centers are created. Medical and surgical diagnostic services and treatment are purchased or otherwise secured from practicing physicians. Hospital care is purchased from existing public and voluntary hospitals. No jobs are set up for placement. Employment is secured in private business and in government on the customary business basis.

We are fortunate to have professional guidance for our national office in our three national committees: The Rehabilitation Advisory Council, composed of outstanding representatives of business and industry, labor, medicine, social welfare, and other interests closely allied to the problems of rehabilitation; the Professional Advisory Committee, representing the medical and technical specialties most actively concerned with rehabilitation; and the Advisory Committee for the Industrial Placement of the Blind.

It is perhaps unnecessary to say to a group of social workers that rehabilitation is a personalized service which must take form according to the peculiar difficulties and aptitudes of each person. Hence, case-work procedures are used in formulating and carrying out individual plans for rehabilitation.

Stated in brief outline, these plans cover nine integral

factors, all or part of which may be required for successful rehabilitation:

1. Location of persons in need of rehabilitation to allay the disintegrating effects of idleness and hopelessness.

2. Medical diagnosis and prognosis coupled with a vocational diagnosis as the basis for determining a complete individual plan.

3. Vocational guidance to select suitable fields of work by relating occupational capacities to job requirements and community occupational opportunities.

4. Medical and surgical treatment to afford physical restoration and medical advice in the type of service to be given and in the work tolerance of the individual.

5. Physical and occupational therapy and psychiatric treatment as a part of medical treatment when needed.

6. Vocational training to furnish new skills where physical impairments incapacitate for normal occupations or when skills become obsolete due to changing industrial needs.

7. Financial assistance to provide maintenance and transportation during training.

8. Placement in employment that will afford the best use of abilities and skills in accordance with the physical abilities and individual temperament, and with due regard to safeguarding against further injuries.

9. Follow-up on performance in employment to afford adjustments that may be necessary, to provide further medical care if needed, to supplement training if needed.

Physical examination, counseling, guidance, training, and placement are available at no cost to the disabled. Medical treatment, transportation, maintenance, and instructional supplies are provided without cost if the applicant is unable to pay for these services from his own resources.

There are certain other limitations with respect to physical-restoration services. In the first place, the services to be rendered must be such as may be expected substantially to reduce or to eliminate the employment handicaps. Also, treatment may be given only for conditions that are "static." It is clear that this term was intended by the Congress to differentiate the conditions to be treated under this program

from ordinary acute illness or injury. We do not feel that it was intended to mean that we must await the end results of a long-term illness, however, before starting services. For example, it would not be necessary to await the onset of total blindness before a person with glaucoma could be treated under this program.

Hospitalization is limited to a period of ninety days for any one disability. This limitation was clearly intended to distinguish our program from those providing long-term care for chronic illness.

To sum up, our rehabilitation program emphasizes constructive medical measures, designed primarily to assist a handicapped person to obtain remunerative employment. Medicine, psychiatry, surgery, physical therapy, occupational therapy, and vocational education—each invaluable—are tools a hundredfold more valuable when used to complement one another.

In establishing the physical-restoration program in our Federal office, we have sought advice both from within the Government and from outside. By agreement with the Surgeon General of the U. S. Public Health Service, our physical-restoration section is directed by medical officers assigned to our office from the Public Health Service. In time, we hope for similar assignment of other medical officers to carry responsibility for us in various specialized fields.

Aid to the states in setting up the work for physical restoration is being given by our medical officers, who are drawing heavily on our Professional Advisory Committee's recommendations in the various areas of service.

At the moment we are in the stage of determining the scope of physical-restoration services; agreeing on standards for physicians and specialists, hospitals, and other facilities that provide services under our state programs; and defining policies and plans for the various groups of disabilities it seems possible for us to serve.

We are encouraging the state boards for vocational education and the state agencies for the blind to seek to establish close coöperation with state agencies in related fields, such as state health departments, crippled children's agencies,

medical boards of workmen's compensation, and the like, for the purpose of correlating the work and avoiding wasteful duplication of services.

We are also encouraging the states to look to the medical and allied professions for advice through the formation of state professional advisory committees and through appropriate medical consultation in their day-to-day operations. It is evident that the medical work in rehabilitation will often be of a specialized character, and in work of this type, it seems to us of the utmost importance that standards be established that will assure the handicapped under our program medical services of high quality. A prudent use of public funds demands this.

As we learn to make use of physical restoration in rehabilitating the disabled, our thoughts turn to work in the fields of psychiatry, tuberculosis, ophthalmology, and otology, in all of which much remains to be done that was not possible under the old law. I hope we shall see special projects for service in these fields established in many states to discover the most satisfactory methods of rehabilitating persons with handicaps from such causes. Such studies in fields not hitherto thoroughly explored will be very valuable as guideposts to enable all states to undertake the restoration of difficult cases.

Earlier I told you that the mentally as well as the physically handicapped can now receive vocational rehabilitation through our program. The importance of this development is apparent from the experience of World War I. It has been reliably estimated that to date the compensation and hospitalization of its psychiatric casualties have cost over one billion dollars, and furthermore that the peak of admissions to veterans' hospitals of veterans of the first World War has not yet been reached. In the present war the rate of rejections by army induction centers for psychiatric defects is higher than in 1917–1918: 23.2 per cent of the rejections have been for mental disorder or defect, neurological conditions, and mental deficiency, according to data from the Selective Service System published in the Congressional Record. The incidence of mental disorders in the military

services is also higher; according to the Congressional Record, more than 44.6 per cent of the discharges from the armed forces have been due to these causes.

In commenting on the high cost of caring for mental casualties of World War I and this present rate of rejections and discharges, Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, Washington, has called attention to the significance of including the mentally handicapped for rehabilitation. To quote, "The increasing knowledge of the mental mechanisms involved has resulted in a new attitude on the part of the physicians and the public—an acceptance of the fact that conditions of this sort are treatable and many of them curable."

Dr. Overholser's opinion that a good deal can be done for certain types of mental disorders is shared by many eminent psychiatrists and obviously was in the minds of Congress in enacting our new legislation. We all know that a man unfit for military service is not necessarily less the useful citizen, for daily we see men who can do a good day's work in shop or factory, but who would be a total loss on a battlefield or even in a camp. We find hope also in the experience of service men, who, after severe hardship, have developed psychiatric disorders from which they have recovered to become as useful as they were in civilian life. Looking upon mental illness, therefore, as an expression of incongruence between the adaptive problem to be solved and the capacity of the individual to solve it, we are attempting a rational and sympathetic approach to rehabilitation for this group of the disabled.

Our consideration of the rôle of psychiatric assistance in our program is from two angles, relating to those physically handicapped persons who have mental and emotional conflicts to complicate the problem of physical rehabilitation, and to those persons who are handicapped by a primary psychiatric disorder, particularly those with early mental illness.

Discussing the subject at our recent Professional Advisory Committee meeting, Dr. Karl M. Bowman, of San Francisco, President-elect of the American Psychiatric Association, reminded us that there is as yet no body of knowledge on psychiatry in rehabilitation. He suggested that probably

our efforts should be directed to the use of psychiatry in relation to the psychosomatic disorders and the psychiatric concomitants of other disorders—the first defined as complaints that are referable to organs or organ systems, although primarily traceable to emotional conflicts, such as neuro-circulatory asthenia; the second as exemplified by the psychoneuroses, as recently reflected in the psychiatric review of groups of orthopedic patients. The types of mental illness that occur to us immediately, in any consideration of the rehabilitation of psychiatric patients, are mental deficiency, epilepsy, psychopathic personality, psychoneurosis, chronic alcoholism, and drug addiction. It is apparent at this time that some of these groups may be neither eligible for nor capable of rehabilitation within the limitations of our program.

Sources from which it is anticipated cases will come are the mental hospitals, especially the family-care and parole groups; clinics; family welfare and relief agencies; and persons receiving rehabilitation services under other parts of our program.

We expect to rely upon psychotherapy, occupational therapy, physical therapy, and the general upbuilding of the physical condition for supplemental treatment, marshaling also the social services for the general manipulation of environmental factors that relate to rehabilitation.

Two questions doubtless arise in your minds as we discuss rehabilitating the mentally handicapped—namely, with regard to employment opportunities and to protection of the confidential nature of the diagnosis.

At first the selection of employment objectives may be somewhat circumscribed by the employment fields that are open to persons rehabilitated from mental illness, since some employers have definitely debarred persons known to have had a diagnosis of even a mild anxiety neurosis. We shall hope for, and strive for, a broadening of work opportunities as our program progresses.

In the matter of protection of the confidential nature of diagnoses, it is our policy to safeguard every case by the establishment of the professional relation between rehabilitation agent and client, in which our agency binds itself

scrupulously to respect the confidence it requires. We are discussing with other agencies of the Government the establishment of additional safeguards that may be useful in preventing a diagnosis of mental disability from becoming a "scarlet letter."

In a general sense, it is probably true that an indirect contribution is made to the mental health of every person who receives services under our program. The mere knowledge that vocational rehabilitation is a public service for their needs is a morale builder. The philosophy of the program develops mental strength to overcome handicaps. Frustration is removed by the substitution of the definite objective of return to employment through practical job preparation, while the whole process of counseling and guidance tends to evaluate emotional problems and to aid in their adjustment.

The framework of our program and our new working tools set the sights on our goal. As the first step in that direction, our current active case load of disabled persons receiving rehabilitation services is 91,000. The states estimate this number will rise to 110,000 with the fiscal year 1945, which begins in July. On a comparative basis, we are, therefore, just about at par with the normal annual disablements for whom rehabilitation is needed. The tempo must accelerate rapidly to attack the backlog of disablements and to meet the war load. We are enheartened in our work by the widespread interest in rehabilitation; by some outstanding examples of industrial effort toward solution of the problem; and by the fine record the handicapped are making in war industry and essential business.

Your organized and individual help, and that of other groups having a stake in rehabilitation, is vitally related to our ultimate aims—the restoration of every possible person to the economic independence of self support.

SOCIAL WORK IN SELECTION FOR THE ARMED FORCES*

TYPES OF PROBLEM THAT WOULD HAVE BEEN DISCOVERED WITH BETTER PRE-INDUCTION SCREENING

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IT is an axiom that every person, even the most stable, might crack under certain conditions of prolonged strain. With those men who temporarily show the strain of severe fighting, we are able to cope adequately. It is the men who show personality peculiarities before induction who are of primary interest to us. Most of these can be detected by means of adequate screening, and their elimination saves the government a good deal of time and money. The persons with whom I shall be concerned here are those who could be screened through a study by social workers of community collateral records, such as public records, social-agency records, school reports, and medical records.

The psychopathic personalities comprise a group that could be eliminated by and large if community resources were utilized to a greater degree. In this group one finds the glib and convincing talkers who may have developed physically and intellectually in a rather adequate fashion. In spite of that, however, a certain emotional immaturity and personality pattern persists. This group is represented by individuals who act out their difficulties and who are characterized by strong drives to seek out immediate satisfactions and pleasures irrespective of the results of their acts. In this group one finds the pathological liars, the swindlers, the gamblers, the tramps, the eccentrics, the alcoholics, and the drug addicts. Almost invariably a social history on these individuals would have brought out delin-

* Presented as part of a program on "Social Work in Selection for the Armed Forces" at the Seventy-First Annual Meeting of the National Conference of Social Work, Cleveland, Ohio, May 14, 1944.

quency in school, juvenile or police offenses, and a poor work history.

Categorically, the psychopathic personalities are readily detectable in their communities. The schizoid personality could easily be discovered by means of a social history. These individuals are extremely hypersensitive and are ill at ease among strangers. They are introspective and seem to build a wall about themselves. Because they are considered queer in their communities, they can be spotted more easily and eliminated from the service. The cycloid personality, with his periods of euphoria and depression, creates a morale problem in the army. These individuals to a great degree could have been eliminated had the induction board had access to collateral material.

I should like to emphasize that psychopaths or antisocial personalities can be weeded out through the use of adequate documentary records such as institutional records, prison and court records, and social histories. This group is of particular interest to the army because of their emotional instability and ethical inaptitude. These individuals are almost invariably insubordinate and usually end up in the stockade, where they continue their agitation. In this group one finds the majority of criminals, pathological liars, and kleptomaniacs. In the army as in civilian life, they are usually in conflict with the police or with other authorities.

The group that comprises the homosexuals is as a rule difficult to detect from home studies. The fact remains, however, that since they make up 2 per cent of our adult population, a considerable number of them will get into the army. Greater care is needed in detecting them because they can so easily lose themselves in large communities. It is felt that a thorough psychiatric examination would be helpful in their elimination.

In the past a great number of mental defectives have been able to get into the army. I should like to emphasize that a more thorough examination, as well as a social history, would help to eliminate this group. In order to compensate for their feelings of inadequacy, these men develop numerous bodily complaints and end up riding the sick book daily.

More adequate collateral records will keep out of the army habitual alcoholics, confirmed drug addicts, and psychotics. There have been instances where alcoholics, drug addicts, and even ambulatory psychotics were discharged from institutions in order to get into the army, under the mistaken impression that the army would cure them.

In the past, a number of men with enuresis have been inducted into the army. Although some of them are capable individuals and make good soldiers, their enuresis is a health and morale problem and for that reason they are undesirable for military service. A social history on these men would save the government a lot of money and at the same time protect the men from untold and unnecessary difficulties which by virtue of their problems they face in the army.

Individuals with more severe emotional disorders are less difficult to detect. Invariably their instability is of longer duration and they are known in their communities as queer or unstable people. These can well be eliminated through the procuring of documentary records, such as social histories from local agencies, school records, or medical reports.

Another group that could be eliminated through the study of collateral material is the group of those suffering from structural disease of the nervous system. A great number of these individuals get through the screening tests because their difficulties are minimal and not disabling. It is only after their induction that their problems become apparent. In this group one finds individuals with syphilis of the nervous system, epilepsy, post-traumatic syndrome, multiple sclerosis, and other degenerative diseases of the brain and spinal cord.

In conclusion, I should like to stress that the greater use of collateral material by induction centers will eliminate a higher percentage of men who should never be inducted into the army. Also of great importance in the doubtful cases is a more thorough psychiatric examination by competent individuals rather than merely a brief screening test.

PROBLEMS FOUND IN AN ARMY MENTAL-HYGIENE UNIT THAT COULD NOT REASONABLY HAVE BEEN PREDICTED BY PRE-INDUCTION HISTORY AND EXAMINATION

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THE question I shall attempt to answer here is: What type of personality might have a breakdown in military life that could hardly have been predicted from a civilian history and a brief psychiatric examination?

For purposes of pre-induction screening, men might be divided into three groups:

Group I—Those men who, upon induction, present symptoms that render them unfit for military duty and who should be deferred from service. These Sergeant Edelson has discussed.

Group II—Those men who present no apparent symptomology upon induction, but whose life adjustments are such that they may break down in service as it is now constituted. These I shall discuss.

Group III—The remainder of the men, who will complete training successfully, but who may, of course, develop trauatic neuroses under combat conditions.

The group of men of whom I speak have, through a process of trial and error, arrived at a life adjustment in civilian life that, while excessively dependent upon extraneous factors, allows them to function successfully. These men usually will appear quite adequate in screening examinations, and it is not until their life pattern is disturbed that the tenuous nature of their adjustment is revealed.

Numbered among such men are those who are extremely compulsive. Contrary to popular opinion, experience at our mental-hygiene unit indicates that such men do not find satisfactions for their compulsive needs in the army. Instead, they are completely shaken by frequent transfer and the impossibility of achieving any semblance of permanence in the army. The army is routinized, to the average

private at least, in minor matters; in more important aspects, it is completely unpredictable.

Associated with such compulsives is the man who has suffered from moderate migraine. Such persons have often adjusted to their symptoms and have integrated them into the life pattern. Coming into the army, frustrations are increased and such persons, being psychiatrically unable to avail themselves of the limited means offered in the army for expressing aggression, find their headaches increasing as their tension mounts.

The passive-dependent man with functional ailments finds himself in a similar difficulty, with the added handicap that his sickness no longer affords him the same gratification of passive-dependent needs that it did in civilian life. Similarly, the passive-dependent man without a functional ailment, who in civilian life adjusted through the satisfaction of dependency needs in his home or his job, often will break when he finds himself totally dependent upon an impersonal organization without the love values that made his civilian dependence situation protective.

Conversely, the schizoid personality, who found a satisfactory life adjustment as a lone wolf, may break down when he finds himself in a situation where privacy is denied and his inability to establish satisfactory adjustment to others is traumatically brought to his attention. The narcissistic individual, who in civilian life has been able to feed his own ego at the expense of his environment, soon finds the going rough in the army where the individual is submerged and opportunities for self-direction and self-expression are very few. Lastly, we might mention three latent conflicts that can easily be handled in civilian life, but that are strongly reactivated in the army.

First, there is latent homosexuality, activated by intimate contacts in a world of men and a lack of opportunity for normal sexual outlets.

Second, there is a rejection of father figures, activated by the presence of hordes of superior officers, all of whom may appear threatening and punitive.

Third, there is the need for a mother figure, activated by the absence of anything like a mother surrogate in the army.

In summary, men who are extremely emotionally dependent, narcissistic, compulsive, seclusive, or rebellious against parental authority may readily make precarious, but adequate civilian life adjustments and hence come through screening procedures into a life that will be extremely threatening to them.

It should not be inferred from my remarks that in my opinion all such men should be kept out of the army. It has been the experience of the mental-hygiene unit at Drew Field that many such men can, with brief therapy and such environmental manipulation as is possible in the army, make an adequate adjustment and be of some value.

Adjustment is a function of person and situation. It is our experience that the adjustment potential of the men described varies directly with their morale.

While morale is composed of many elements too complex to discuss here, the most important are:

1. That the soldier know what he is fighting for and believe in the validity of these aims.
2. That he feel that the war aims are shared by the entire community, and that all are making some sacrifice for them.
3. That he have confidence in his leaders' ability to achieve these aims.
4. That he have confidence in his comrades to support him.

With these four convictions, a man can take a good deal of personal deprivation without developing symptoms.

THE MEDICAL SURVEY PROGRAM IN MINNESOTA

ALLAN STONE

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THE Medical Survey Program of the Selective Service System has now been in operation for several months. Those of us who have been privileged to participate in the program as it is now established, and in the earlier experiments and unofficial screening programs previously in effect, should pause briefly to examine our progress up to this

point, our present problems and procedures, and the future of the program as we in social welfare can relate our efforts to the task of Selective Service and to the community as a whole.

Many of us have had various experiences and varying degrees of success in effecting the furnishing of social-history material for the use of armed-forces induction stations. The main purpose of this paper is to give a picture of the program in one area and in one state; to review the procedures, problems, and operations, as well as the scope of the program; and to attempt to measure the effectiveness of our work, and the relation of social workers and social-work agencies to those Federal agencies officially charged with responsibility for the processing and induction of men for the armed forces.

The lack of available social histories and the limited amount of time that the examining psychiatrist has at his disposal have resulted in the induction into the armed forces of many thousands of men who are suffering from psychiatric or personality difficulties of one kind or another. It has been well established that the psychiatrists at induction stations have been seriously handicapped by a lack of necessary background information relative to the registrant's adjustment and by the pressure of processing large numbers of men.

In the short space of time allotted for the psychiatric examination, it has often been impossible to determine with complete accuracy the existence of psychiatric disabilities—disabilities that may come to the fore after induction into the armed forces. How many men with epilepsy, syphilis of the central nervous system, low mentalities, emotional instability, psychoses, or neuroses have been passed by the examining physicians at the induction stations, it is impossible to determine with any degree of accuracy. It is safe to say that the number is large.

It has been found that many men with such disabilities have been able to adjust satisfactorily to civilian life. However, the problems put before them by their entrance into, and service in, the armed forces may cause an intensification of the disability or a complete breakdown. Our experience has clearly indicated that in many instances inductees with

a history of a psychiatric disability have broken completely in military service. These same men, it was often found, had been making fairly satisfactory adjustments to civilian life prior to their induction. The transition from civilian to military status, the regimentation, and the fear of combat duty were factors that well may have led to their breakdown. In some instances these men inflicted bodily harm on themselves and on their fellow soldiers and civilians. The result of this situation in many cases has been that some men require institutionalization, while others may have had their chances for recovery seriously impaired.

What is the measure of the situation in terms of damage to the individual—and of financial burden to the government and to the community? It cannot be argued that much damage has not been done to many who have been inducted, but who should have been screened out at the induction station. In addition, the armed forces gain nothing substantially from what service such a soldier finds it possible to perform. In varying degrees, he may often have been detrimental to the morale of the unit in which he served. Figures based on the experience of World War I indicate that the cost of care of men who suffered acute mental breakdowns while in the armed forces and who needed institutionalization varied from thirty to fifty thousand dollars per man. It is clear, therefore, that from a social and a financial standpoint, adequate psychiatric screening of such men prior to their actual induction is tremendously more economical to the services and to the community than the care necessary after the breakdown has taken place.

Communities throughout the country are receiving, in increasing numbers, men discharged from the armed forces because of mental breakdowns or personality maladjustments. Social agencies, both public and private, in each community have known many of these men and their families and have been acquainted with the past history of existing problems.

Soon after this situation had developed to somewhat alarming proportions, many persons in the social-welfare and the mental-hygiene field felt that if the examining psychiatrists at the induction stations were supplied with data bearing on the case history and the psychiatric disabilities of the registrant or his family, their ability to make a closer

check of the fitness of the registrant for military service would be greatly enhanced. An important phase of this process of selection was the securing of social data bearing on the registrant and his family.

Prior to the establishment of the Medical Survey Program, no provision was made in the Selective Service regulations for the establishment of a screening program or for the use of trained social workers, except as may be inferred in Section 623.33 of the regulations, which provided:

> "d. Local Boards, with the assistance of the examining physician and such agencies that may be designated by the State Director of Selective Service, should seek from any source possible information bearing on a history of mental disease in the family of the registrant, or social maladjustment, poor work record, other mental or personality disorders of the registrant, or any physical condition which might cause the armed forces ultimately to reject the registrant."

On the basis of available facts regarding the situation and discussions held with persons in the community interested in the problem, it was possible to evolve a program designed to furnish the armed-forces induction station with such medical and social-history data as the several health and welfare agencies might have in their possession. This program, as it was drawn up, was one which social agencies, public and private, could easily organize and place in operation.

The growing interest in the program on the part of those in the field of social welfare was sharply accentuated by some of the more tragic examples of mental breakdowns among men in service.

An experimental program for the furnishing of case summaries on Class 1-A registrants was established in St. Paul and Ramsey County on January 1, 1943. This program had the approval and support of the State Director of Selective Service for Minnesota.

Necessarily, the program was built around the needs of the local situation and the facilities that were available for the gathering of data and the preparation of social-history information. The medical officers of the induction station at Fort Snelling gave complete support and coöperation to the program and made full use of the reports sent them.

The program was originally set up as a part of the St.

Paul Council of Social Agencies. To an executive committee composed of psychiatrists, welfare administrators, and case-workers was assigned the responsibility for the general policies and operation of the program; while the case-work committee was charged with the review of case histories and the preparation of case summaries for the use of the induction station. This latter committee is composed of psychiatric social workers, case-workers, and psychologists drawn from the case-work agencies in the community.

After a short period of successful operation of the program as it was established in St. Paul, the Minnesota Selective Service Headquarters authorized a similar program for Minneapolis and Duluth, thus covering the three urban centers of the state; and in the summer of 1943 an adaptation of the St. Paul program was put into operation for the rural counties of Minnesota. Thus, by August of 1943, all counties and all local boards in Minnesota were participating in a program designed to furnish social histories on men being processed at the induction station. The success of the program in Minnesota and the ease with which it was operating, together with the fact that it closely paralleled procedures outlined in the Medical Survey Program, necessitated very little change-over when the latter program was announced.

Local boards obtained identity-verification cards on all registrants in 1-A or classified from 1-A. In the urban centers mentioned above, the cards were submitted to central screening offices in the respective areas; in the rural areas, to the local county-welfare-board office.

In Minneapolis, St. Paul, and Duluth, the cards were checked against the files of the respective social-service exchanges, and in the rural counties, against the files of the county welfare board, before being sent on to the Minnesota Division of Social Welfare for checking against the state central index. All registrations of public and private agencies, correctional and mental institutions, and health agencies are available in each of the four exchanges for residents of the area that the exchange serves.

Selected agency and institutional registrations are noted on the identity-verification card and a standardized social-agency report form is sent to those family and children's

agencies, guidance clinics, and health and welfare agencies that know the registrant or his family or both. The report forms, one or more of which may be sent out for each registrant, are completed by the case-workers in the several agencies and are returned to the case-work committee, the members of which have now been appointed medical field agents.

When, upon review, it is determined that pertinent data are available relative to psychiatric or personality difficulties of the registrant or his family, a social history report (DSS 212) is prepared. Prior to the advent of the Medical Survey Program, the report was called a "case summary" and was sent, in a plain envelope marked for the medical examiner, to the local board for transmission to the induction station at the time the registrant was examined. Medical Survey Program forms are now used, but the procedures in Minnesota closely follow those previously in operation.

Thus, at the time the Medical Survey Program was officially announced, Minnesota had a successfully operating program for furnishing social-history information relative to men being inducted. A word must be said here for the splendid coöperation of Selective Service and induction-station officials, and of the many social workers throughout the state who have given of their time and energies to make this program effective.

Brief mention should be made of the expanded phase of the work of the medical field agents in Minnesota under the Medical Survey Program. In the urban counties of the state, the medical field agents are assigned to a pool, or central office, and all of the local boards in the area refer their cases to the central office. In this way supervision can be given to the work of the agent, the work load can be more evenly distributed among all of the medical field agents, and much clerical work can be distributed to the non-professional staff. In the rural counties of the state, where, in most instances, the only social agency is the county welfare board, one or more welfare-board staff members are assigned as medical field agents to the Selective Service Board in that county.

The State Director of Selective Service, in ordering the change-over from the then operating screening program to

the official Medical Survey Program, wrote the local boards as follows:

> "The several social workers, assisting in the Medical Survey Program, have been appointed as medical field agents . . . . All local boards are to consider medical field agents as appointed by and as part of the Selective Service System. In addition to assisting in the Medical Survey Program it is believed local boards may use medical field agents in assisting in many other problems. Among those would be investigation as to the basis of facts as regards statements which may be subject to question, such as statements of epilepsy, hay fever, bronchial asthma, to use a few examples. The medical field agents may also be used by local boards to assist them in investigation regarding dependency, facts as to consideration for Class III-D, or investigation to determine facts upon which to consider discharge from the armed forces because of dependency."

Revised War Department regulations place in the hands of the state director the responsibility for recommending discharge from the armed forces by reason of dependency. In Minnesota the medical field agents have been designated by the state director to make such investigation as may be necessary to aid the local boards in determining and weighing the facts.

Those familiar with the Medical Survey Program have at one time or another raised questions regarding its effectiveness. How have the medical and social histories been applied and what has been the ultimate acceptance or rejection of registrants on whom histories have been prepared? As stated above, we have always had full coöperation from Selective Service and induction-station officials. The nature of the program and the procedures at the induction station, however, make it difficult to follow through with each report to the point of the psychiatric examination, in order to determine the value of the data supplied in the social history report.

Induction-station medical officers have stated that on occasions the registrants would have been accepted for military service had it not been for the social-history information reported in the summary. Obviously, in many cases pertinent information reported to the induction station is also noted by a psychiatrist during the course of the examination. The primary purpose of the program has been to provide the examining psychiatrist with pertinent information regard-

ing the registrant, which information would be of assistance in determining fitness for military service.

In St. Paul the social-service exchange identifies two-thirds of all identity-verification cards cleared. The case-work committee has prepared reports for the induction station on slightly over 9 per cent of all men and 13 per cent of all cases identified.

On a group of 697 reports prepared in St. Paul during the first nine months of operation of this program, the distribution of action is as follows:

Action taken	*Number*	*Per cent*
Accepted for military service	269	38.6
Accepted for limited service	11	1.6
Granted deferment	16	2.3
Awaiting examination	38	5.4
Over induction age	2	.3
Conscientious objector	1	.1
Rejected for military service	360	51.7
Total summaries prepared	697	100.0

Slightly over half of the men for whom summaries were prepared were subsequently rejected for military service. To this will be added a proportionate number of the 38 registrants who were at that time awaiting examination. While the figures for rejection at the Fort Snelling induction station are not available, it is known that the total rejection rate at that time was substantially less than the 52 per cent reported for men on whom summaries were prepared.

At this point in the Selective Service program it appears that the volume of work we shall have in the Medical Survey Program will be substantially less than was previously the case. We should not, however, relax our efforts to strengthen the program and to give consideration to its future possibilities. Social work and social workers have effectively demonstrated that they are able to step quickly into this type of program and to render valuable aid to the Selective Service System and to the armed forces.

We are certain that without this program many men likely to suffer breakdown in service have been kept in civilian duties where they have been able to function satisfactorily and to add their part to the total war effort. The subsequent human and economic loss that has been prevented with the

aid of the Medical Survey Program has demonstrated that the program, operated at a small cost to health and welfare agencies in the community, has paid for itself many times over.

OPERATION OF THE MEDICAL SURVEY AT NATIONAL AND STATE LEVELS

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WITHOUT the kind of development in local communities that Mr. Stone has described, the establishment of the Medical Survey Program would not have been possible. The experience gained in early work done in Massachusetts, Connecticut, New York, New Jersey, Arkansas, Colorado, and in various cities with developments similar to those of St. Paul and Minneapolis, not only convinced us that social work can be used effectively as an aid in selection, but also made possible the formulation of a workable plan for national use.[1]

Developments during the past year have really been remarkable. A year ago only six states and a few additional cities were operating programs of history gathering. During the year the Medical Survey Program was developed by the National Headquarters of Selective Service and the social-history feature is now operating, with variations, in forty-two states and the District of Columbia.[2] Two additional states have formulated plans and will start operating the program within the next few weeks.

To trace the development of history-gathering programs and to give a developmental account of the Medical Survey Program might have some historic value, but it seems better,

[1] For information regarding the value of social histories and the significance of the social worker's part in the Medical Survey, see the following articles by the writer: "Social Case-work in Relation to Selective Service and the Rejectee," (*Mental Hygiene*, Vol. 27, pp. 370–89, July, 1943); and "A Challenge to Social Work—The Medical Survey Program of Selective Service," (*The Compass*, Vol. 25, pp. 7–10, January, 1944).

[2] See Medical Circular No. 4, Selective Service System, for detailed information regarding the Medical Survey.

in the time available, to describe its present operation, note the variations used, and briefly survey its accomplishments and current problems.

The facts regarding the present status of the Medical Survey were obtained largely from an inquiry sent recently to the advisers to the various state directors. Some data also were compiled from telegraphic reports recently sent from state headquarters to the national headquarters.

The figures that I shall quote should not be regarded as representing strict mathematical accuracy. The social workers and nurses who are assembling histories of selectees, and the officials of the Selective Service System, are too busy to compile statistical reports on all work done, and of course the situation changes from month to month and almost from day to day, so that reporting as of a month ago is already out of date.

All in all, about 8,000 social workers, public-health nurses, and others have been appointed as medical field agents and are busily engaged, largely on volunteer time, in assembling social and health histories for the use of medical examiners at the armed-forces induction stations. It appears likely that about 75 per cent of these medical field agents are supervisors, case-workers, and investigators in state, city, and county departments of public welfare. There are probably a few hundred public-health nurses assisting in the program. Between one and two thousand social workers employed by private agencies are doing a sizable part of the work in the larger cities. It is estimated that, in addition to the 8,000 who have been officially appointed as medical field agents, there are approximately another thousand persons working in a similar capacity under other titles, particularly in states that had developed state-wide programs before the establishment of the Medical Survey, and in connection with social-service-exchange clearings and the obtaining of reports from agencies through centralized organizational set-ups, as in the state of Pennsylvania. Many of these workers have not been officially appointed as medical field agents or assigned to local boards, but are contributing a vast amount of time in assembling social histories.

There is geographical coverage with the social-history phase of the Medical Survey, or its equivalent, in all states

except Idaho, Nevada, Wyoming, Vermont, Virginia, and Florida. In some of these, clearance against state institional files is made routinely, and Virginia and Florida expect to be operating the full program in the near future.

In most states from 80 to 100 per cent of local Selective Service boards coöperate. In Indiana, North Carolina, Kentucky, West Virginia, and Texas, coverage is limited to some of the larger urban centers and includes only a minority of the boards.

Unfortunately, just at the time the Medical Survey was being established in most states, the monthly calls were extremely heavy, and the shift from induction to pre-induction examinations was being made. As a result, the percentage of registrants on whom histories have been compiled in the last two or three months has been lower than in more normal periods. Taking the country as a whole, and including registrants from states where no program is in operation, it appears likely that about 65 per cent of registrants are cleared against state institutional files, and that social and health histories, on Form 212, are being compiled on about 35 per cent of registrants. A similar percentage probably holds for the school reports submitted on Forms 213 and 214, where an effort is made to obtain histories only on the younger group, particularly those who have been out of school not more than five years.

Coöperation Between Selective Service Boards and Medical Field Agents.—Considering the speed with which the Medical Survey and related history-gathering programs were established, the coöperation between the Selective Service System and social agencies and their workers may be regarded as excellent. Occasionally complaints come regarding an unfavorable attitude on the part of some board, but a very high percentage of boards have accepted the Medical Survey as having real value, and although the operation of the program entails considerable additional clerical work, forms are filled conscientiously and on a surprisingly high percentage of registrants. Many boards fill out the forms on every registrant. In only two states are medical field agents denied access to the Selective Service records, and many boards make a point of passing on to the field agents information in their possession and of referring for special investi-

gation registrants believed to have social or health problems. So far as is known, with the exception of one state, not more than ten boards have objected to the sealing of medical field agents' reports, once they understood the purpose of the program and the uses to be made of histories.

In establishing good working relationships between the medical field agents and the boards, various methods have been used. A method that has proved effective in every place in which it has been used is the holding of regional meetings, attended by the medical field agents, board members, and especially the chief clerks. Such meetings have usually been addressed by the medical officer, or other representative of state headquarters, and by the social-work advisers on the Medical Survey. Such meetings have insured full understanding of the purpose and operation of the program, and, through the discussion periods, have resulted in clarification of the respective responsibilities of every one and the precise procedure to be used.

In a few places this idea has been extended into definite courses. In New York City, for example, there was one meeting of field inspectors to prepare them for giving adequate supervision to the Selective Service boards, and another meeting of all the chief clerks. A six-session course was put on for medical field agents and attended by almost all of six hundred who were appointed.[1]

Previous experience of coöperation between Selective Service boards and social agencies, in the making of dependency investigations and other special investigations, had done much to develop mutual understanding and confidence. The advisers in many states have expressed the opinion that this previous experience helped greatly in making possible the quick establishment of the Medical Survey Program.

In a few states the medical officer of the state Selective Service headquarters has visited all the boards in his state and has given direct supervision to the work of the Medical Survey.

In states where the bulk of work is done by the department of welfare, the county director has as a rule assumed responsibility for making contact with all the boards in his

[1] These six lectures have recently been published by the Family Welfare Association of America, under the title "Symptoms of Personality Disorder."

area, and has worked out with them the necessary arrangements for smooth operation of the program. Quick reporting to state headquarters by Selective Service boards, and to the state adviser by medical field agents, usually results in a prompt clarification of issues at the state level. Joint releases from state headquarters and the adviser, going both to medical field agents and to the local board clerks, have also been helpful in insuring common understanding and smoothness of operation.

Many of us were sceptical a year ago as to the possibility of establishing a nation-wide program of history gathering, unless a considerable measure of social-work supervision could be provided in each state. Doubtless the effectiveness of the program could have been increased somewhat by more supervision, but the extent of the coverage, and the negligible amount of criticism and difficulty that has arisen because of lack of social-work supervision close at hand, are quite impressive.

Procedures Used in Assembling Histories.—The procedures used in assembling social and health histories vary widely from place to place. Social-service exchanges, wherever they exist, are used almost universally. The only exceptions are a few of the large cities, where the cost appeared prohibitive without the assistance of Federal funds. Routine reporting by agencies that have known registrants or their families is an integral part of the program virtually everywhere. In some places the making of such inquiries and the assembling of reports is done centrally, through councils of social agencies or special committees. While the program in some states is limited almost entirely to agency reporting, such reports are supplemented quite generally by the obtaining of additional information through physicians and employers, and also through some medical and legal agencies that do not customarily use social-service exchanges, as, for example, many courts, sheriffs' offices, and hospital clinics.

Interviewing of registrants is used extensively in New York City, Detroit, the entire state of Delaware, and parts of Pennsylvania. In Delaware, every registrant or a member of his family is interviewed. In New York City, interviews are always used, but selection is made of those to be inter-

viewed. In about half the states, families are interviewed in some instances. Information is sought from physicians and employers in a majority of states, but in six or seven states these are never used.

Results.—It is difficult to arrive at an estimate of the results of the Medical Survey. We have not wanted to add to the work of the medical field agents by requiring any routine system of reporting. The best estimate possible, from reports received from various states, is that probably one hundred thousand histories on Form 212 are compiled monthly. Comparisons, state by state, are misleading, because in some states all 212's are forwarded to local boards and induction stations, even though they may have no significant social and health data. In other states—and in this there is an increasing tendency—only those 212's are forwarded which are believed to have significant and pertinent information. Some states report their totals in one way, and some in the other.

The percentage of histories that have pertinent information in the sense of revealing some pathology or history of personal or social difficulties varies, depending on the procedures used in compiling such histories. Where chief reliance is placed on existing social and health records in recognized agencies, the states report from 1 to 15 per cent of unselected 212's as pertinent. When selection for investigation is made on the basis of clues from registrants' questionnaries or registration with social and health agencies, from 20 to 40 per cent of histories reveal valuable and pertinent information. The higher percentages in this bracket apply in places where registrants, members of their families, employers, and physicians are interviewed. In one city, 82 per cent of the histories compiled by special request of the psychiatrist have yielded pertinent information.

Use of Histories at Induction Stations.—Complaints given to me in person during field trips and in correspondence in recent months have had to do chiefly with the uses of the material at the induction stations. A complicating factor has been the fact that induction stations are administered by the nine service commands of the army, rather than by the Selective Service System, and although there has been good liaison between these two divisions, the examiners who were

to use the histories appear in many instances not to have received proper instruction. This has been rectified to a large extent in recent weeks, and there are now many fewer complaints. The past work habits of individual examiners, particularly the extent to which they have worked with social workers and been accustomed to using social data, has been a significant factor.

The pressure under which the medical examiners must work, of course, makes it impossible for them to read any but exceedingly brief histories, and it has become largely the practice to make available to the psychiatrist only those histories which seem to have significant evidence of pathology or problems. This limited use of histories is somewhat regrettable, because it is believed that histories that contain evidence of good health and good work and social adjustment should be confirmatory of acceptance in certain border-line cases that have some appearance of inadequacy.

I am often asked to what extent decisions to accept or to reject registrants are different from what they would have been had histories not been used. This is an extremely difficult question to answer. If the examiner uses the history correctly—that is, to give clues for the better conduct of his examination—it would be difficult for him to determine whether his decision would have been different had he not had such clues and had questioned the registrant differently. It is the opinion of the psychiatric examiners in most induction stations that histories do make a difference in a percentage of border-line cases. The only place I know of where there has been an accidental control group is in Louisville, Kentucky, where one set of 800 histories were used, and another set of 800, comparable in pertinence of information, were not used. Sixty-three per cent of the men whose histories were used were rejected; 52 per cent of the men whose histories were not used were rejected, thus yielding an 11 per cent difference.

In one induction station, during the first day on which histories were supplied, the chief psychiatric examiner reported that five epileptics had been discovered who very likely would have been missed if examined without history. In a recent study of 200 men treated in a rehabilitation clinic, the psychiatrists engaged in psychiatric rehabilitation have

reported that 60 per cent of these men would have been excluded from the armed forces if adequate history making had been done.

Current Problems.—Aside from the problem of incomplete use of the material at some induction stations, there are a number of other difficulties that have not been completely solved. Lack of funds with which to pay for social-service-exchange clearings in the large cities, and, particularly, lack of Federal funds for reimbursement to states in which most of the work is done by department-of-welfare workers, is a continuing obstacle to the full success of the program. This is particularly true in states where the state legislature has severely cut the budget of the department of welfare and requires a strict line-by-line accounting.[1]

There is considerable need for further instruction and encouragement of Selective Service boards, to insure the completion of history forms on more nearly 100 per cent of the registrants. Advisers from various states have offered some suggestions that would facilitate the work of the medical field agents and get somewhat more complete results. For example, it would be helpful if the name of the registrant's physician and present or last employer were included on the 212. In rural areas, it would be helpful if the address indicated the name of the community, as well as the mailing address. A medical release form, signed by the registrant, would clearly facilitate matters in a few states where laws regarding confidential communications are extremely strict. In several states Selective Service headquarters have developed and are using a form on which the registrant supplies these items of information.

There is still insufficient time, in some instances, for the medical field agents to complete their work before the man's examination. It is believed that this situation is now improving very much, since the calls are less heavy and the regulations regarding classification of registrants seem to have been better established, with less likelihood of repeated changes. This will enable boards to classify men earlier and initiate the Medical Survey forms.

Some need is felt in certain states for more adequate inter-

[1] In June Congress appropriated $1,000,000.00 for these purposes for the fiscal year 1944–45.

pretation of the program to practicing physicians, through state and county medical societies or otherwise. In other states complete coöperation from physicians prevails. A need is also felt for more give and take between local boards, medical field agents, and induction-board examiners, and especially for more definite reporting back from induction stations regarding the types of information deemed most valuable. There is some expressed desire for a simplification of forms and procedures, and especially for the elimination of items that the examiners regard of little value or do not use.

There are thus some imperfections in the program at present, but corrections can be made without great difficulty. The impressive thing is that the program was established so quickly, that coverage is as extensive as it is, and that it works so well. The recruitment of 8,000 to 10,000 social workers, and the effective way in which they set to work and are accomplishing this new task of mammoth size, is nothing short of amazing.

THE PSYCHIATRIC SOCIAL WORKER IN AN ARMY STATION HOSPITAL

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PSYCHIATRIC social work in a station hospital differs in many respects from psychiatric social work in a civilian environment. In civilian life the client voluntarily approaches a chosen agency with an awareness of a particular problem. Over a period of months, a close relationship is slowly developed between the social worker and the client.

In a station hospital the situation is vastly different. After one or more visits to his dispensary, chaplain, or Red Cross office, the soldier is scheduled for an appointment with the psychiatrist. Either immediately before or immediately after a brief interview with the psychiatrist, he is sent to an office, where a fellow soldier obtains his story and inquires quite minutely into his early experiences and behavior. Here an attempt is made to discover in a few hours what it may take months to find out in the civilian practice of psychiatric

social work. The principal concern is directed toward the elicitation of the soldier's history in an attempt to determine his fitness for army service.

The social worker's approach to the patient is friendly and direct. The question, "What is your trouble, John?" usually starts off the interview. Neurotic patients are traditionally great complainers, and the interview is aimed at utilizing this source of energy to the very best advantage. Until a patient reaches the neuropsychiatric clinic, he undergoes upsetting experiences. Before he can come to the clinic, the patient will have had to report on "sick call" and face the searching or sarcastic stare of the first sergeant, who is constantly on the lookout for what he thinks are "goldbricks." Then the soldier will be sent to his regimental dispensary, where he is given a brief examination by the medical officer. The latter, frequently frustrated by the absence of physical findings, often curtly returns the man to duty. It is generally after several such visits to the dispensary that he is finally referred to the psychiatric clinic at the hospital for diagnosis and disposition.

The social worker's attention is at first directed toward easing the patient's tenseness and his nervousness, increased and intensified by the procedures of the army just described. To aid us in this, we have found it expedient to display no insignia indicating rank and to wear white coats instead of the regulation uniform. Tone of voice, friendliness of manner, absence of military insignia are all directed toward making the patient forget that he is in a military situation and to assure him that some one is sincerely interested in him and his problems. Smoking is allowed and encouraged with the offer of cigarettes to the patients.

In contrast to the military situation in which the soldier has been living, with its emphasis on hardness, and with its impersonality and regimentation, this procedure makes the establishment of rapport a relatively easy task for the social worker. He then listens to the complaints of the patient and clarifies them with skillful questioning. Time and again, with a husky voice, and with evident relief, after speaking with the worker for five or ten minutes, the soldier will say, "You are the first person I have been able to talk with since I have been in the army."

At times we meet soldiers who have built up a veneer of protection against the usual impersonality and gruffness of the army. They don't expect a sympathetic hearing and distrust this kindness. Frequently they have difficulties of a personal nature, involving conflicts of which they may be very much ashamed, and they attempt to cover up their main difficulties. In such cases, time must be given for the rapport to develop.

If the patient continues to be uneasy, tense, and uncomfortable, we recognize with him how difficult it is for him to talk about his troubles. At that point the interviewer explains that he is a soldier trained in dealing with personal problems, and that his primary purpose is to help the patient. The confidential nature of the information is stressed. An explanation of the professional status of the interviewer is necessary in dealing with sensitive clients who feel that they cannot discuss their private affairs with just "some soldier."

After the patient has given a spontaneous description of his symptoms, we direct the questioning toward the development of his present illness. We inquire when the symptoms began and under what circumstances they originated. Was there any fluctuation? Was alleviation sought, and what were the results of treatment? Did the symptoms affect civilian adjustment? How have they been influenced by military life?

Our next questions very naturally have to do with the patient's adjustment to army life. How did he feel about being drafted? Why did he enlist? (Probing as to reasons for enlistment often uncovers factors in addition to patriotism.) How is he meeting the rigors of basic training? How is he affected by the continual rush, the confusion, the emphasis on physical strength and endurance, the imposition of discipline, the lack of individuality, the lack of privacy, the enforced changes in his daily habits? The reality of the rifle range, with its lesson of shoot first and accurately or be killed, is frequently the precipitating factor in the development of severe anxiety states or hysterical reactions. Underlying insecurities and apprehensions burst forth on this first very poor and minor approximation to battle. Preparation for fighting is brought home to the trainee at the rifle range, even if he has not realized it before. This is repeatedly

brought to his attention as he progresses to the obstacle course, the battle-conditioning course, and the landing-tower exercise.

How does he mix with his fellow trainees? Are they too gruff for him? Is he "one of the boys," or does he stay by himself? Has he had any disciplinary actions taken against him in the company? Do they discriminate against him, make him do all the extra work? Is he satisfied that his classification and assignment are correct and properly related to his previous education and experience? How does he like the army? Caution must be employed here because patients may become defensive, since they do not wish to implicate themselves in any way. Thus it is more significant of the intensity of his feeling when the soldier's hostility breaks forth and he admits his dislike for the army. At the social worker's discretion, this question may well be left until the conclusion of the interview, where it will have no possibility of jeopardizing the newly established rapport. On the other hand, it is felt that an acceptance of dislike for the army might enhance and enrich the rapport.

After obtaining the complaint, the development of the present illness, and reactions to military life, our inquiry follows the usual pattern of a psychiatric history, with its chapter headings of birth and development, neuropathic traits, health, school and work records, sexual development, habits and interests, social and family relationships, personality and family history.

Although all facts of the entire history are considered, the school and work records are the two single items that contain the data of most value to the psychiatrist in appraising the soldier's personality and in prognosticating his army adjustment. The school record provides us with an approximation to the soldier's intelligence and early social adaptability. From the work record we learn if the soldier fully utilized his capacity and opportunities. If, as the result of his complaints and his personality traits, his employment was irregular and inadequate, we tend to expect a similar adaptation to military service.

We might include a few notes about the relationship between psychotic patients and the social workers. Frequently a soldier will be sent to the clinic with somatic

complaints, but to the trained worker with a knowledge of psychiatry, abnormalities of a psychotic nature will be detected. Close association with competent psychiatrists and frequent discussions of symptoms and areas of questioning have resulted in the ability of the social worker to elicit from the patient much psychotic content. The extremely suspicious and evasive psychotic, with no complaint, is a test of the social worker's abilities to win over and secure the confidence of the individual in question. When patients are not too much disturbed, complete histories, as outlined above, are secured from them all.

In addition to obtaining the psychiatric histories, the social workers in the hospital also function as psychometricians. The army's routine testing program is principally concerned with group testing. While this is adequate for the vast majority of soldiers, there are many cases in which individual testing is required by the psychiatrist. Men who cannot read or write, foreign-born soldiers, or those who took their tests while still under the influence of their pre-induction celebrations, will frequently require individual tests. It is necessary to determine what part of a man's maladjustment to his army duties are due to mental deficiency.

The Stanford-Binet (new revision) and Army Wechsler are the intelligence tests most frequently used by our department. As a performance test with non-English-speaking soldiers, we utilize the Kohs block test. If he has not had adequate training in civilian life, each social worker gets thorough personal instruction in the administration and scoring of the tests.

Although complex in its scoring and interpretation, increasing use is being made of the Rorschach personality test. This is administered and scored by a social worker trained in the Rorschach method and is interpreted jointly by the social worker and the psychiatrist. We have found this test to be of value in differential diagnoses of psychosis and psychoneurosis, and of psychoneurosis and malingering. It has also been helpful, in certain cases, in indicating the severity of a neurosis and has influenced our decision as to the disposition of the soldier—retrial of duty or discharge from the army.

Psychotherapy is limited in many respects within the bounds of the station hospital by the very large case load, by

the patient's short stay in the hospital, and by the inflexibility of the army environment and the necessity for a rigid training program. It is of necessity that we are pragmatic in our approach. We are able to secure an alleviation of some of the symptoms and an improvement in adjustment by attacking the presenting problems and situations, without delving thoroughly into the psychopathological dynamisms.

The social worker performs a useful function in assisting with the treatment of the psychiatric patient. The psychotherapeutic efforts of the psychiatrist are supplemented by the mental-hygiene approach of the social worker. There is no question that our patients are disturbed individuals when they first come to our attention. Their symptoms reach such an intensification, in what to them is frequently a hostile and non-understanding environment, that mere ventilation of their problems affords them some measure of immediate and noticeable relief. The cathartic value of "talking through" one's difficulties is well known to all case-workers. Particularly does this assume importance when it is realized that the usual outlets for relief—friends, relatives, parents—are no longer available to the newly inducted soldier.

It is a continuing source of amazement to the social worker that in so short a period of time he can delve so deeply into a patient's problems. Conflicts and worries that the soldier has never confided to any one and that have been irritating him for years are readily divulged. Immediate improvement follows the disgorgement of such suppressed material.

For some of the intelligent, better-educated, withdrawn, or timid soldiers, just "the chance to talk with somebody intelligent" means a great deal. To be treated and accepted as persons of interest and congeniality, after their rejection (often mutual) by their military comrades and non-commissioned officers, is a personality-saving experience for this group of soldiers.

Many of the men view their symptoms as signs of weakness of character. They feel that their admission to the hospital is a sign of a lack of courage, of an inability to face and endure the rigors of army life because of a "weakness in the will to succeed." These men strongly express a desire to do things for their country. They feel ashamed that already they are weak, and develop strong guilt feelings. Deeply

interwoven with these feelings is the inability to admit and to accept a personal failure in a particular situation in which so many men have been able to succeed. This was typified in the feelings of a very sensitive and well-educated officer candidate who, upon learning of his probable discharge, burst into tears, saying, "I set myself a goal and I failed!"

Interpretation of the nature of the neuroses, of the rôle of the emotions in the production of somatic symptoms, and emphasis upon the universality of neuroticism, the frequency of feelings of insecurity and fear in most people, all help to give the patients a healthier perspective. The exoneration from self-blame for their symptoms and stress on their past sincerity and attempts to stick out their duty help to minimize their growing guilt feelings. Repetition of these reassurances are frequently necessary, and the social worker is revisited by the patients or stopped time and again in the hospital corridors to discuss these same problems.

Patients returned to duty must be made to view their hospitalization as an opportunity for a "second wind" and not as a refuge from or evasion of the requirements of duty. Ideas and attitudes of sickness and disability are discouraged. The patients have to be prepared for a renewal of army life. They know that they are being sent back to the same situation in which they previously had serious difficulties. In addition, either they have to face the curiosity of their fellow trainees as to their hospitalization, or else they have to attempt to fit in with a newly arrived group of strange recruits. Supplementing the broad therapeutic approach sketched above, special attention is paid, in our discussions, to the rôle of *military* factors in precipitating the soldier's symptoms. With a new understanding of themselves and the ways of the army, the patients are better prepared to work out their adjustments to military life.

If a discharge is decided upon as the best disposition for his case, the soldier soon becomes involved in several conflicts related to his dismissal from the service. In spite of the fact that a discharge may have been their main objective while on full duty, nevertheless psychoneurotic patients frequently lose their enthusiasm for the dismissal from the service when it is within their grasp. It is extremely hard for them to accept the fact that they are not considered good army

material. It shows that they "can't take it," that they can't "make the grade." Probably every man—even though not in the army—has at some time or another indulged in phantasies in which he was rewarded for extraordinary military heroism. It is hard for the dreamer to realize and to accept the fact that this will no longer be possible. Then again, men in uniform enjoy the consideration given them by civilians and the priorities extended them by various agencies. They are caught in the reflected glory of their fellow soldiers fighting overseas. Pride in the army, its achievements, its status, and its aims, make it extremely difficult for men to envision the resumption of their civilian status.

Not only must the social worker help solve these underlying conflicts, but he must be able to meet the often expressed fear of the patient of facing the home front. Many patients do not know what a "CDD" (Certificate of Disability for Discharge) is. All patients fear the stigma of a "medical discharge" on grounds of nervousness. What will they tell the people back home who can see that they have no physical disability? How can they return in good health to the same office in which they were given such a fine send-off party before they left home? How will they be able to get a job with a "discharge saying that they are no good to the army"? Who will want a "cast-off" to work for him?

The social worker can assist the patient by helping him to understand the situation more clearly, by explaining away the stigma of a medical discharge, and by enlarging upon the need for men of all types in civilian life to aid in the war effort. It has proved helpful to point out that patriotism does not begin or end with war, and that there are many ways in which one can be patriotic and contribute to the welfare of our country even though one is not in the armed services.

Recognition of this problem by the War Department resulted in the following statement:

> "Since this problem exists, all medical officers concerned with the rejection or discharge of men for psychiatric reasons will use painstaking tact in making the individual aware of the fact that he would be unable to adapt himself to the rigors of Army life and that he could serve his country better in a defense industry or other gainful occupation. Any other suitable reason may be given. In this manner the reason for the person's returning to the community can be explained

> to him, and the frame of mind in which he is returned to civilian life can be dealt with in such a way as to avoid severe hardship and may possibly help to salvage that person for some gainful occupation at a time when all available manpower is essential."[1]

When questioned as to their intentions when they leave the army, many patients declare that they are going to take a rest or a vacation. This attitude is common in spite of the period of hospitalization preceding discharge. Readjustment to civilian life is fraught with as many dangers to the personality as adjustment to army life. A "rest" is an easy way of postponing the required adaptations. Insecurities attendant upon civilian life, perhaps covered up by the new environment of the army, are intensified as they emerge and superimpose themselves on the patient's recent failures in the army.

Particular emphasis is given here to the fact that just because the soldier has been diagnosed as "psychoneurotic" is no reason for him to feel that his symptoms have become aggravated. Diagnosis in itself is the mere labeling of symptoms that have been present and known to the soldier for a long while. Encouragement is given that the patient will be able to function as well as he did before his military service, and that he should take up his civilian life with hope, courage, and enthusiasm.

One of the most important functions of our psychiatric service, however, is to bring about a realization in the patient that he is in need of some psychiatric help. Although the soldier may have had difficulties for years in making satisfactory adjustments as a civilian, up until his hospitalization and disposition he may never have realized the true nature and seriousness of his problems. Dismissal from the service causes the patient to view his complaints with a new earnestness. With a new perspective on himself and on his problems and the hope of finally getting at the seat of his maladjustments, the soldier is placed on the path toward mental and emotional health. It is up to our civilian colleagues to carry him further along that path.

The experiences and duties of the social worker in a station hospital are rich and varied. Close daily association with

1. *Rejection or Discharge for Psychiatric Reasons:* War Department Extract No. 42, Headquarters Third Service Command, March 9, 1943.

psychiatrists is most instructive. In addition to weekly staff conferences at which various clinical problems are presented for discussion, detailed analysis of any case—its onset, symptomatology, diagnosis—is available to the social worker for the asking. The variety of material that comes to the attention of the worker runs the gamut of neuropsychiatric abnormalities, including all types of psychotic, psychoneurotic, and psychopathic reactions. Textbooks come to life in the daily work of the psychiatric department.

Current reports of men with psychiatric disorders among battle casualties emphasize the importance of recognizing these conditions during the early training period. The social worker is becoming an effectual and necessary adjunct in the detection and disposition of these problems in the army.

The future need for psychiatric social workers in the rehabilitation of soldiers will be great and pressing. The transition from soldier to civilian, with its many unforeseen adjustments, will be difficult for millions of "normal" men. The reorganization of industry and the replacement of women and children in industry by men will create many situations in which the social worker will be in great demand. The experiences of the social worker in a station hospital are of inestimable value in his preparation for the resolution of these problems.

DELINQUENCY IN ADOLESCENT GIRLS *

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NO one can deny that social crises or periods of continuing group stress produce changes in the habits of living of many people. We cannot escape the very drastic changes of social living thrust upon us by wars and by periods of financial inflation or depression.

One of the common assertions of social fact to-day is that delinquent behavior is on the increase among adolescent girls. News accounts remind us almost daily of the rising tide of juvenile offenses. A governmental agency reports an increase of over 100 per cent in sex delinquencies among minor girls in a two-year period. School men make similar claims, and rumors are prevalent about "moral conditions" in areas where army or naval units are stationed. The issue of juvenile delinquency appears in municipal political campaigns, incumbents recognizing limited increases and contestants searching for higher figures and citing the laxity of their opponents in enforcing laws.

More sober analyses of available facts (and they are few in number) lead to two conclusions: first, war time brings no new problems, only familiar problems in a new setting; and, second, there is an indubitable increase in offenses among boys and girls, but this increase is probably somewhat less than press accounts would indicate. For a number of reasons, social statistics are peculiarly elusive, and trends vary considerably according to the community. One may cite a marked increase of offenses in a certain city, but fail to recognize that the population has also increased phenomenally in the same period. Other communities show clear decreases. The clinical point of view very properly registers alarm over conditions as found in particular places; an over-all view shows that "bad spots" tend to be balanced by areas of improved adjustment, and that the net increase

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for the country as a whole is possibly more apparent than real.

Presumably where there is such persistent rumor, there may be some fact, and undoubtedly misbehavior among adolescent girls has increased in the last two or three years. In peace time the typical delinquent girl is a sex delinquent; in war time, while petty theft may be more frequent, sex behavior is still the greatest source of difficulty. As in peace time, a significant reason why juvenile girls are so much more likely than boys of the same age to be involved in sex offenses is that girls reach physical adolescence somewhat earlier than boys and frequently have as partners individuals outside the juvenile age range.

When one attempts to list psychological factors in sex delinquency, one is forced to consider social-psychological factors as well. The individual is always behaving in a social group and is adjudged delinquent in terms of the standards of that group. For convenience, social and psychological factors can be grouped roughly under two heads: those related to social change in general and to relaxation of sex mores in particular, and those more clearly individual and psychological in nature.

Important among the more obviously "social" influences, which are yet closely related to "psychological" factors, is the changing social control of behavior. Sociologists and social psychologists generally recognize that the intimate and primary groups called in-groups are very important in forming attitudes and in modifying activity. War activity creates many new in-groups. Uniformed organizations with particular behavior codes exist for those who enter military and semi-military service. The defense worker constitutes a new group, with a certain status and certain responsibilities and privileges not exactly comparable to anything in peace-time living. The girl working the night shift, with her slacks, kerchief-cap, badge, and lunch box, belongs to a kind of uniformed in-group. Young boys and girls not yet out of school find employment and become members of groups other than their school classes.

The formation of new groups permits new codes of behavior to develop. Individuals form associations outside of the familiar neighborhood and home circles, and the tendency

is to let down somewhat the customary restraints on behavior. While this factor is more directly operative with older adolescents and adults, their spirit of daring is subtly communicated to younger adolescents, who also are inclined to venture.

All-out war effort brings marked geographical mobility to certain occupations and individuals. Construction workers, welders, skilled machine operators may take their families along in their migrations. The young adolescent in such a family is uprooted, and like many youthful British evacuees, may come to like the excitement of change and unconventional circumstances. An increasing number of young girls are traveling to join families or to visit friends, some at army camps. Among the occupants of any coach on any train to-day will be a number of persons who, traveling for the first time in their lives, are finding such travel exciting and status-giving and are seeking reasons for more travel. Removed from familiar scenes and social controls, they find changes in conduct standards and in behavior relatively easy to make.

A third important point has to do with the waning of family controls. Over a period of decades, the significance of the family in the education and training of young people has been gradually diminishing. Now, in a social emergency, a father may be absent on the Alaskan highway, or in a West-Coast shipyard, or he may be in the armed services. A mother may be working as well as the father. Parents who work longer hours or who are themselves more preoccupied with personal cares or insecurities will give less attention to children and youth. However the normal pattern of parent-youth relations may be altered, it has in specific cases detrimental effects on the behavior of young people. When one adds, to decreasing familial supervision, the fact of a great reduction in community facilities for youth, one must recognize the inevitability of some increase in juvenile misbehavior.

Finally, many young girls find opportunities at jobs with certain moral hazards. Waitresses, domestic workers, maids in hotels have taken more lucrative tasks; on every hand one encounters girls of less maturity and social experience in jobs that offer opportunities for casual sex contacts.

These factors do not operate equally and probably have a

different significance for younger than for older adolescents. They all contribute toward changing our habits of living. There is little question that in times of rapid social change, the usual controls on behavior are relaxed, and there are more individual defections from conventional sex mores, among both adults and young adolescents.

Psychological factors are numerous. First, there is the incentive to sex exploration created by the maturation of physiological process during adolescence. Human development offers many illustrations of the principle that the development of structure appears to carry with it an impulsion to use the structure. Child training frequently consists in channelizing and curbing the indiscriminate, random utilization of such functions. This is true whether one considers the language development of the young child, the motor development of older children, or the sex development of adolescents. Thus, in a sense, the incentive to sex behavior, in our society considered undesirable among unmarried young people, is a "normal" drive, whether in peace time or war. It has been suggested that in peace time we expend considerable energy in curbing and channelizing this need, because failure to do so may be costly to the group, but that in war time we turn our energies to the curbing and control of fear tendencies. If this analysis is sound, we have here a partial explanation of the relaxation of sex mores that appears to accompany warfare.

Clinicians have frequently asserted that unusual sex behavior—autoerotic or heterosexual—can be found in lonely, insecure, and unhappy adolescents. Such an individual seems to be seeking in his person a gratification for a broader affectional or social urge when familial or group satisfaction of that urge is missing. The security lost at home through the absence of one or both parents or by lessened attention from them, and the security lost as one's group of contemporaries is broken up, may thus provide in some individuals a strong incentive to sex behavior.

A factor that cannot be separated from the broader social picture is the glamour traditionally associated with the military uniform. In war time, an aggressive masculinity is emphasized, and the psychological as well as the biological rôles of the sexes are reaffirmed. When contacts are casual,

when one does not live in the vicinity of his or her partner to be constantly reminded of one's violation of the code, when the mores are changing anyway, it becomes relatively easy for certain individuals to transgress. Primitive responses undoubtedly come to the front in human behavior in a world at war; sex as well as combat is an ancient response of human kind.

An additional point should be made. During the 1920's and 1930's, it became increasingly difficult for a young person to get a job—indeed, in city life, to get any work experience whatsoever. During the depression years, young people were constantly reminded that they constituted a social problem—that the world did not need them. Within a year or two, this situation has been completely reversed. Young people have become desirable, even vital to the successful development of the social order. Whether at home or in military service, young men and women find themselves carrying great responsibilities; their younger brothers and sisters, too, have found unaccustomed opportunities and responsibilities.

As has been mentioned, the young adolescent girl working after school hours faces problems and decisions that her older sister did not meet until later in her development. In a sense, the young girl is being thrust very suddenly into her psychological adolescence, where older girls have been more gradually "eased" into that experience. All this takes place in individuals who until quite recently led the sheltered and irresponsible lives so characteristic of modern urban culture. It is conceivable that many delinquencies arise from young people's ignorance and bewilderment in the face of unaccustomed responsibilities and decisions.

Two explanations of sex delinquency frequently given by the man in the street may be discounted. The modern girl does not give her "all" as a poorly directed expression of patriotism, to assist the need of a man in uniform. Nor do young people, confronted with great uncertainties, even doubts of survival, actually seek experiences normally regarded as the fruition of adult adjustment in married life. These arguments appear, rather, to be rationalizations for other, less readily perceived forces, certain of which have been mentioned.

This brief paper could not presume more than to initiate

consideration of its topic. It is not my purpose to discuss the more pathological expressions of sex, which are with us in peace as well as in war. Such cases do not well illustrate the argument of this paper; they are the products of peculiar sets of forces and circumstances rather than of the more general "trends of the times." The social-psychological factors reviewed—the formation of new in-groups; the geographical mobility of individuals and families; lessening of the attention, supervision, and control given to children and youth; the employment of youth in morally hazardous occupations; the development of war-time conditions that foster personal insecurity; the strong recrudescence of primitive impulses in war; and the sudden impact of psychological adolescence on individuals generally unprepared to meet it—all these factors and many others form a complex web of multiple causes for sex delinquencies in young girls. Just as no one factor can be advanced as a primary cause, so no one treatment can be offered, though, in general, any development that will act to stabilize personal relationships and experiences in a world of rapid change will probably check the trend. An increase in juvenile delinquency, however small or great it may be, is a true indication of the stress in our society to-day.

FAMILY CARE AS THE FOCUS FOR SOCIAL CASE-WORK IN A STATE MENTAL HOSPITAL*

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PSYCHIATRIC social case-work in state mental hospitals has not developed in accordance with the anticipations of thirty years ago. In spite of the problems that have confronted the administrators of these institutions as a result of lack of opportunities for social rehabilitation of their inmates, more than twenty states had, at the end of 1940, no social-service programs at all. Although there were highly organized services in a few states, the development in general was uneven.

I believe that one reason for this slow progress has been the reluctance of institutional psychiatrists to recognize the need for social case-work. As a result, social workers have had difficulty in finding a place for themselves in state hospitals. On the other hand, there have been few workers who have been willing to remain in one position long enough to gain sufficient understanding of the total institutional situation to visualize and to define the basic area of need for social-work skills. Most workers who have accepted positions in state hospitals have shouldered such tasks as history taking, liaison duties, pre-parole investigations, and follow-up work. While the performance of these duties was helpful, they were not considered essential to the functioning of the institution, and they were certainly not sufficiently distinctive to contribute to the professional prestige of the social worker.

There has been little recognition of the opportunities for social case-work in an environment within which many people spend their entire lives under specific and necessary limitations. Instead, there has been an identification with the

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psychiatric function, and the worker has tended to become an extension of the psychiatric rather than a proponent of an allied profession, with distinctive characteristics of its own. These distinctive characteristics, however, must be sufficiently related to psychiatry and institutional life to become integrated with the purpose of both.

I believe that family-care placement is the means by which this goal can be realized. Where it is an accepted practice, the psychiatrist recognizes supervision of patients in family care as a service that is distinctive and essential to the functioning of the institution, since it offers an opportunity for community adjustment to patients who could not otherwise leave the hospital.

Family care, as it is practiced in Maryland, was started in 1935, under the supervision of the writer, at Springfield State Hospital.[1] Here it is defined as the placement of mental patients who are ready to leave the hospital in the homes of persons to whom they are not related by blood or marriage, when no other suitable community plan is available for them.

As there was no boarding fund until 1940, the selection of patients for placement during the first five years was limited largely to those who were working in the hospital and who were believed to be employable in the community. A few of them received assistance from social agencies or were boarded by relatives. The patient who did the housekeeping or who waited on table in the dining room was seen not only as a person with peculiarities and quirks, but also as an individual who might be able to adjust in the community.

The selection of the homes was made much as child-placement agencies select homes for children, with the realization that an adult could fit productively into the natural family constellation in the rôle of grandmother, aunt, grown son or daughter, maid or handy man. This obviously excluded placements on a competitive basis with a family member or another patient in the home.

The remarkable improvement in initiative and self-confidence of these patients was encouraging, and gradually, as this method gained recognition, patients were referred for

[1] See "Family Care Placement of State Hospital Patients as a Method of Situational Therapy," by Katharina Stuber and Henrietta B. DeWitt. *The Psychiatric Quarterly*, Vol. 16, pp. 144–55, January, 1942.

whom family care had more to offer therapeutically, at a particular phase of illness, than the hospital environment. The success of this experiment created for the social worker a distinctive function, which became the focus of psychiatric social work in this hospital.

The ability to work with a patient in family care implies, on the part of the worker, an understanding of the meaning of hospitalization to the patient and of the use that he is able to make of this experience for growth. Not unless the social worker understands the reorganization that has taken place within the patient, step by step, can she know the fear and uncertainty with which he faces each new situation. The fact that her function is centered in family care leads her to evaluate the patient's progress in terms of social adjustment.

To the patient, commitment to a state mental hospital is a tragedy. It represents utter repudiation of self and total ruin. With it, the last vestige of responsible relationship is severed and he feels completely abandoned behind locked doors. To the fear of being trapped is added the terror of the evidence of his own apparent insanity. He struggles at first against the catastrophe that has befallen him, but finally yields to its inevitability. With the acceptance of the stark reality in which he finds himself, a new self begins to emerge. This is expressed in the affirmation of his own difference from those about him; and in the process of individuation, he gradually reaches the optimal level of his adjustability. Many of these unfortunate individuals never find their way out of the maze of mental illness sufficiently to leave the hospital; but those who do are the special interest of the social worker.

In the protective environment of the hospital world, life acquires form and purpose at a very simple level. Concomitantly with receiving modern scientific treatment, the patient is making a social adjustment to his new surroundings. He learns, first, to tend to his own needs, then to participate in the ward work and to help others less capable than himself. The fact that he is needed and that his efforts are appreciated gives him an experience of success. This furnishes an incentive toward more responsibility, which increases his self-confidence. Thus he measures his recovery through his ability to function in successive rôles of increased responsibility. He sees others ahead of him getting beyond the

locked door for a few hours a day, then transferred to the increased freedom of another ward. Finally, he is moving about with assurance in an open cottage and is beginning to look toward the next step, parole.

In returning home, however, disaster sometimes follows because the patient is suddenly faced with the complications and responsibilities that healthy people take in their stride, but that are often too strenuous for him. He is not yet ready for the competitive position in which he finds himself. Family care offers the intermediate environment in which such a patient can take this next step. In it he encounters not too great a difference from institutional life and he is able to utilize the relationship in which he finds himself for further progress.

The writer began her work at Springfield after a period in which a variety of social-work activities had been carried on by one worker. With the new definition of social work as family care, the department developed rapidly until, by the end of the fiscal year, September, 1942, it consisted of a chief social worker, six assistant workers, and two students in training. Although the number of beds in the hospital had increased by only three hundred, the number of patients on parole had increased from two hundred to more than six hundred, including one hundred and forty active family-care cases. Discharges had increased 47 per cent. The increase in the number of the patients in the hospital had slowed down in 1941, and there were actually fewer patients in the hospital at the end of the fiscal year, 1942, than there had been at the beginning. This was somewhat offset, however, by the fact that there had been slightly fewer admissions to the hospital during the year. During this period—from 1935 to 1942—the social-service department, through the development of the family-care function, had become integrated with the hospital function and was regarded as an essential part of it.

With this conception of family-care placement as the focus of development of the social-case-work service, there emerged an increasingly clear differentiation of the psychiatric and social-case-work functions. Social case-work became dissociated from therapy and recognized as a service available to patients who needed assistance with their problems of social adjustment. As these relationships became clarified, they

resolved into a method of working with patients which could be extended to the conduct of the intramural service and parole.

In this paper, which is concerned with the clarification of what I believe to be the valid basis for social work in a state mental hospital, I have found it helpful to view the problem as it appears in the training of a new worker, whose experience in this strange environment in some respects parallels that of the patient.

In each new worker the supervisor in the state hospital meets not only the attitude of the lay person to mental illness, but also the adjustment of the individual himself to the unusual institutional setting and to all the exigencies of a new job, the procedures of which are not established, but are in process of development and must be translated into methods that can be taught through class and field work.

The new worker is confused not only as to her function, but also as to her surroundings and her attitudes toward mental illness and mental patients. Regardless of the efforts that may have been made prior to her employment to help her discover a little of the reality of the situation, she rarely gains even a glimpse of the true picture. She usually comes into the institutional world motivated by a desire to become identified with psychiatry.

Coexistent with a certain glamour that psychiatry holds for her is a fear of mental illness and mental patients. Her uncertainty is so great that, during the initial period of insecurity, it is not unusual for the novice in this field to experience an uncomfortable awareness of her own mental mechanisms. She is awed by the medical staff. On the wards, she stares at the patients with pity or revulsion, not seeing the individual because it is all too different, too big. There is much that she finds difficult to accept and much that needs interpretation.

Discouraging as are her first impressions, family care itself helps her move toward acceptance as the ultimate end. It helps her to see wellness instead of illness and difference. She sees the patient coming out, and gains her first concept of her function as one of helping him toward that end. She begins to differentiate her function from that of the psychiatrist, which she sees as treating the patient's illness.

The supervisor realizes that, for the new worker, introduction into a situation that contains so much of the unknown is bound to arouse a tremendous amount of fear resistance and negative reactions of all kinds. Only by wise and skillful supervision can the worker's anxiety be lessened and her energy be released to move toward acceptance of the job and security.

The supervisor is faced with questions of the assignment of cases and the use of function and structure in establishing a support to which the worker can relate and through which she can be related to the institution. She must understand the new worker's need in the beginning to relate to the negative aspects and limitations of the institution in the expression of her resistance to the job, and her need of being helped to bring out these feelings in order that she may gain insight into her own activations. The goal in supervision at the end of six months will have been achieved if the worker has become oriented to her surroundings and her functions.

Psychiatric social case-work and psychotherapy are so closely related that it is impossible for the worker who has had no experience in a psychiatric agency to disentangle their different functions. Therefore, in order to help the worker clarify her position, supervision must be focused on the social case-work function, so that the new worker will gradually be able to separate her relationship to the patient from that of the psychiatrist. She must be helped to recognize the patient as a person in need of a particular service that comes within the framework of the agency's function. This service the worker is able to give through her knowledge of the helping process. The dynamics of his mental illness as such are not stressed, but emphasis is placed on the social problem he presents and on his ability to help.

In this approach the worker is able to relate herself to the comparatively familiar in social case-work until she is gradually able to encompass the unfamiliar in this difficult function. As the worker brings the problems of each new case to the conference period, the supervisor is able to help her define her function. She gradually begins to find herself in a rôle that is different from, yet related to, that of the psychiatrist. When she is no longer confused in these relationships, she is able to gain a comprehension of psychotherapy and

a redefinition of her function in relation to its aims. Through defining her own function, she also helps the psychiatrist clarify his rôle in relation to social case-work. Psychiatric staff presentations, contacts with physicians, and free access to the staff library furnish opportunities for the new worker to satisfy her interest in psychiatry.

An essential part of the training of the new worker in a state mental hospital is teaching her to be able to interpret the hospital to the relatives of the patients and to the community. She can thus help them to obtain a broad view of its purpose as a place for treatment, designed to provide opportunities for living, working, and playing for a group of people who depend upon its limitations for their maximum freedom.

State hospitals have been handicapped by isolation and lack of community understanding. Because of the fear, hopelessness, and disgrace commonly associated with mental illness, and its lack of human appeal, it has been difficult to interest the public in the institution's progress, aims, and activities. Because of ignorance of the facilities of mental hospitals, they are often used as a last resort for those with whom the community has reached a dead end. This attitude not only militates against the improvement of conditions in these institutions, but enchances the fear of those coming to them and obstructs the path of those who are ready to leave. When family care is the focus of social case-work, it brings the hospital into close relationship with the community. Problems of isolation disappear, as confidence is created by the social worker.

Through her contacts with relatives, social agencies, and other professional resources, the social worker in this field has a real responsibility for a dynamic interpretation and an intelligent integration of the state-hospital service into the community. The need to do this becomes spontaneous when she becomes related to her job. She comes to see the hospital setting—with its groups of cottage-type buildings, spread over rolling wooded and farm lands—not merely as a hospital with modern treatment facilities and a well-trained medical staff, but as a community whose industries and recreational facilities are largely sustained by the labor of its patients.

She learns to accept the limitations of the institution and

to work within them. She recognizes the handicaps due to limited help and financial resources, but learns to evaluate them. She hears of isolated instances of unkindness to patients, but she also sees faithful attendants who have devoted their lives to the care of the patients, planning parties for them and taking them home with them on their days off.

She learns that the principal difference between the modern state hospital and the private mental institution is in the type of treatment for which each is designed: the latter is planned for the care of cases of acute illness; the former cares for chronic patients as well as those who are acutely ill and who cannot afford private-hospital care. She also learns that while private mental hospitals may afford more intensive treatment on an individual basis, and greater physical comfort, the modern state hospital has one great advantage in treatment: its patients are furnished a powerful dynamic for recovery in that they must share the responsibility of helping to operate the institution. The majority of its patients have either original or residual defects which render them inaccessible to verbal psychotherapy, and for them situational therapy offers a sound method of treatment. The social worker sees that, from the time of admission, treatment is aimed toward helping the patient achieve self-responsibility, and that personal liberty is increased as the patient is able to use it.

She does not fail to see the tragedy of mental illness, but when she sees that patients can accept mental illness and do adapt themselves to life in a mental hospital, she learns to accept the reality of it. She meets them in all the hospital maintenance departments, in occupations varying from laborer to office worker. She gets to know them as individuals, some of whom, under conditions of fair competition, feel themselves accepted for the first time in their lives. She realizes that many of them would never be able to have elsewhere the freedom and satisfaction in living that they enjoy within the limitations of the institution provided for their own protection.

Moving among these people and administering to their needs are many employees, heads of maintenance departments, and representatives of several professions, each con-

tributing according to his own skill and training in relation to the whole. When the new worker finds acceptance in her own rôle as part of this setting, yet related to the community by the very nature of her profession, she becomes the logical intermediary to interpret the hospital to relatives and to the community.

Skill in interpreting the hospital to the patient's relatives finds its most significant expression at the time of admission in the function of history taking. Only the experienced worker can meet the emotional impact of this situation. The relative usually brings the patient to the hospital as a last resort and, as a result of preconceived ideas regarding insanity and mental hospitals, is very fearful when faced with the reality of this necessity. He identifies with the patient's fear and resistance, and is overwhelmed with conflicts and feelings of guilt. The fact that the social-work function is focused on family care helps the worker to achieve a relationship to the relative and to the patient that is different from that of any one else in the hospital. Even at the time of admission, she is implicitly related to his leaving and is able to inject a positive attitude that carries beyond hospitalization to parole.

On the admission service, the worker finds that the relative is her client. In the relationship that she establishes, she conveys to him the importance of his contribution to the patient's treatment, which is to supply essential information that will aid the physician in making the diagnosis and in planning therapy. As a result of this concrete experience of participation in the interest of the patient, the relative is helped to take responsibility for his part in bringing the patient to the hospital and is thus helped to resolve the attendant guilt.

Few social-case-work situations require of the worker greater understanding and skill. The manner in which this interview is handled may to a large extent determine the patient's course in the hospital. The worker must be able to answer questions intelligently, and she must be able to ask personal questions with a frankness and an ease that inspire confidence and release the other from his natural inhibitory reticence. Treatment begins here, and in helping

the relative take responsibility for his part in it, the worker also helps him to accept the hospital and the changes that may occur in the patient's condition. The relative comes to the hospital in desperation, visualizing this step as the end, but through the help he receives, he leaves feeling that this may be a beginning.

At Springfield the admission procedure is carried out by the joint participation of the physician and the social worker. Formerly this service was conducted by the physicians alone and cases were referred to the social worker for histories only when the relatives could not come to the hospital. This method was never considered satisfactory because the physicians' histories lacked necessary information regarding the patient's social adjustment, and the social worker did not have the skill to obtain the medical facts in many of the complicated conditions the cases presented. The service as it is now conducted is proving adequate, and furthermore offers greater emotional security both to the patient and to his relative.

On arrival, the patient and his relative are received in an attractive admitting office by the social worker, who through her understanding welcome minimizes their bewilderment in relation to the impersonal enormity of the institution. She explains the admission procedure and attends to their physical comfort until the arrival of the physician a few minutes later.

The social worker accompanies the patient into an adjacent office, where he is examined by the physician, who notes his impressions and instructs the social worker regarding specific information he may want to secure. The physician gives the relative an opportunity to speak to him, and then tells the relative that the social worker will obtain the information regarding the patient that the hospital will need.

In the meantime a nurse has been called, and when nurse, patient, and doctor leave, the worker and the relative decide whether the history is to be given then or by later appointment. A later appointment is sometimes better, but cannot often be arranged because of distances and the problem of transportation. Where relatives are unable to come to the hospital, a visit is made to the home to obtain the history.

The new worker is not able to handle admissions effectively until she has gained security in her function. She not only must know and have confidence in the hospital, but she must be able to separate herself from the layman's point of view to be able to understand the relative's problem and to help him.

Until the new worker reaches this phase of training, her need to protect herself from the emotional impact of the situation tends to obscure the relative's problem. Involved in the procedure of history taking, she tends to see the patient as her client, and is more conscious of her responsibility to the doctor than to the relative. Her first history assignments are cases whose relatives cannot come to the hospital. Not so much is demanded of the worker emotionally if she interviews the relative in his home after he has become accustomed to the patient's being in the hospital.

After she has mastered the technique of history taking, she is placed in the admission service, where this duty at first becomes a routine business, boring and monotonous, to be escaped if possible. She regards the relative as tedious and difficult, and frequently complains of his circumstantiality. She feels inhibited because she rejects the relative, yet she has no valid relationship with the patient. In her identification with the doctor, she has no identity with her own rôle.

She brings her feelings of frustration to the conference period, but not until she has become secure in her function does she become aware of the relative for the first time. The following is an account of an interview related in conference by a worker who had experienced this change. It illustrates the use of history taking to help the relative accept the hospital and his part in treatment:

> "Mr. and Mrs. P. came to the office by appointment to give us the history regarding their son, who had been admitted to this hospital a few days before. Already, on the day of admission, Mr. P. had impressed me as a rather tense, nervous man who definitely wanted to be the head of his household and who demanded of his wife and children complete respect to his wishes and plans. Mrs. P. seemed rather quiet and shy, almost apologizing for being here. On the day of this interview, the couple presented much the same picture. When I asked them to come into the office, Mr. P. got up at once, while Mrs. P. seemed to think that she had to wait in the outside waiting room. I made it quite clear that the interview was meant for both of them.
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> "In the office, both parents seemed ill at ease and answered questions

in a very evasive manner. I pointed out that I had to ask such questions not for the sake of personal curiosity, but because the treatment our medical staff would prescribe would depend partly on their answers. Mrs. P. responded: 'Then we are really helping him, aren't we?' And I agreed with this. From that point on Mrs. P. was willing to coöperate, but she and her husband seemed to be unable to agree on anything; so I asked the husband to wait in the outer office and explained that I was going to take the history first from the wife and then from the husband. He left the office, a picture of disapproval.

"Almost the first thing Mrs. P. said was: 'I would never have brought Meyer here, but he [meaning her husband] wanted it.' I commented that a state hospital was pretty frightening, wasn't it? Mrs. P. complained that she could not even phone us. Here I explained that this must be a misunderstanding—that after all we are not a prison and that we could be reached by phone. Mrs. P. seemed a little relieved, but said that, in her opinion, what the boy really needed was glasses. I wondered whether she thought that the boy's loss of weight, his use of extremely bad language, his accusations of and threats to the family were all due to his bad eyes. Rather hesitatingly she explained: 'My husband always said that Meyer was kind of sick, but my husband is so very impatient. Meyer always was different from other children, and that used to worry me.'

"I suggested that maybe Meyer was really sick and maybe he needed the treatment no family could give, but a hospital could provide. After all, hospitals like ours were set up to help with the sort of problem her son presented. She then asked whether I thought that her son was mentally sick. She and her husband had had so many arguments about it and she still felt so bad about having 'put him away.' I asked if they would have kept him at home if he had been suffering from T.B. The answer was no. Well, I continued, it was the same with mental sickness, but for some reason most people felt that mental sickness was a shame and a state hospital a disgrace. Mrs. P. looked out of the window and commented: 'It is right pretty out here.' She also mentioned that she had seen some of the patients come home from work and wanted to know whether, if her son became well enough, he also would work in the fields.

"It was only after I had described the hospital somewhat in detail that Mrs. P. had the courage to ask how her son was getting along. When I explained that progress in almost any mental sickness was slow, but that I had seen her son resting in bed and being fairly quiet, Mrs. P. seemed to be able to accept the fact that he was a mentally sick boy.

"After having taken the boy's history, which was given easily in detail, I asked Mr. P. into the office. His first comment was: 'Usually I have the first word in my home.' I replied: 'That may well be the case, but here in this hospital consideration for your son comes first. We are interested in getting the best history, and the best history is the one which will enable us to be of greatest service to your son.' He took this up at once, saying: 'That is what I want—to do what is best for the boy. I could have kept him at home, but he would have got worse, not better.' He later admitted that he used to 'holler' at the boy, but that his wife would spoil him.

"I asked whether he had at times thought that his son was mentally

sick. Mr. P. confessed that he had. But right after this admission he had to point out that there had been no other mental sickness in his family and that his own mother had raised eight normal children. I took this up, using the opportunity to inquire about his own family history, which he related with a good deal of pride.

"After this, Mr. P. seemed ready to talk about his son's history, pointing out to me incidents in which he had noticed something 'peculiar' in his son's development. He had been bothered because the boy had such a hard time learning to talk. He was almost three years of age when he began to speak and then he stammered badly. His wife had said that the boy would outgrow it, but he had been skeptical. Later in school the boy had had learning difficulties. All along he had thought the boy was just plain lazy, but maybe he had been wrong.

"Defensively, Mr. P. pointed out how all his life he had wanted a chance for higher education; now he had offered this chance to his son, and his son did not take it. Here I commented that maybe his son could not take it—that it was beyond his capabilities; perhaps the question was not one of his not wanting to learn.

"Step by step Mr. P. and I went over Meyer's life history together. Painful as the struggle was to relive his relationship with his son, in so doing, it served as an opportunity for him to come to terms with his own overwhelming guilt toward his son as well as toward his wife. As if in need of reassurance, he would remark: 'I was right there,' or, 'Here I made a mistake.' He brought out how he had perhaps overstressed Meyer's peculiarities, while his wife had been inclined to overlook them. This had caused a lot of friction; argument had followed argument, until family life had become almost unbearable.

"I commented that possibly his wife's nerves and his own were rather strained because of the constant tension. Maybe it was better for both of them, as well as for their son, that they had given him into our care, for we were not personally involved. To us their son was a sick boy whom we would like to help to the best of our ability, within given limitations. Mr. P. smiled and said: 'I don't expect you to perform miracles.'

"I then called the wife into the office and it was possible for the parents to give the rest of the history together, without quarreling and arguing. Before leaving, Mr. P. said: 'My wife and I will try to coöperate with the hospital. We know you will do what is best for the boy.'"

After admission, with the exception of liaison activity, the social worker has had little contact with the patient until he was referred for family care or parole follow-up. The acceptance of social case-work in the intramural service has been a slow process. With family care as the focus of social work, the worker sees the hospital environment as similar to the world outside, in spite of its necessary structural limitations. She is aware that many of the same problems of social adjustment that exist in the community at large are present in the institutional community. The validity

of her professional relationship to problems such as jobs and the need for personal satisfaction through recognition are as real to her within the institution as in the community. With the development of social case-work in the intramural service and its coördination with the family-care program, the barrier between hospital and community will be removed for many patients.

There are patients who have become permanently hospitalized because for years they have been looked upon as indispensable in a particular job. There are also others who just sit because of lack of opportunity and guidance. While the farming and industrial programs are not to be underestimated as therapeutic aids, their primary purpose is the maintenance of the institution. Department supervisors carry this responsibility and depend on patient workers. Care must be taken that these patients move on toward community adjustment, so that their progress and the progress of others are not impeded. Social case-work is needed here to organize the industrial program into job opportunities that could be coördinated with family care and parole.

I firmly believe that the smooth running of the hospital would be facilitated if social case-work assistance were made available to those patients who participate in its industrial work. This not only would insure the best qualified help for the various departments, but would also increase the individual patient's opportunity to pursue his own trade or to learn a new one, if the character of his illness necessitated a change of occupation.

The casual reader may feel that this type of assistance should be included in the scope of occupational therapy. I disagree with this opinion on the ground that the emphasis in occupational therapy is avocational rather than vocational and that its real purpose is therapeutic, while the assistance rendered by the patients in the industrial work of the institution is essential to its operation and vocational in character. The ability of the social worker to participate in the patient's movement on this level would also in many cases expedite parole because of the increased conscious use that could be made of hospital occupation as preparation for a job in the community.

When the patient is ready for parole, he quite naturally looks forward to return to his family. He is prepared to take this momentous step by his physician, who is in contact with the relative who is to assume responsibility for him. The social worker has no part in the parole plan except where her assistance is requested in specific cases. This occurs, for instance, where the physician feels that a pre-parole investigation of the situation to which the patient will return should be made, or where there is no suitable home to which he may return and family-care placement is recommended.

Because of the lenient Maryland commitment laws, patients may be admitted to a state hospital by court commitment if they are inebriated or have been judged criminally insane. With rare exceptions, all others are committed by the authority of two physicians' certificates. As a result, most patients move in and out with almost as great freedom as they do in general hospitals. Except in rare instances where a patient may be dangerous to himself or to others, or be exposed to abuse from which he would be incapable of protecting himself, he is permitted to leave regardless of his condition. This is effected simply by the request of a responsible relative, who is merely required to sign a form relieving the hospital of the responsibility of his care. The parole period is one year and the patient may be returned to the hospital at any time during that period if his condition warrants it. At the expiration of the year, the patient is discharged unless his condition is such that a renewal of parole is indicated.

In preparing patients and relatives for the parole experience, the physician explains the out-patient service to them. Relatives are requested to bring patients to the clinics two weeks after leaving the hospital. Routine letters are also sent, asking them to attend. Their attendance is not obligatory; but, in cases where the patient does not respond and the physician feels that he might especially benefit by the contact, a social worker may be asked to visit the patient to interpret further the assistance offered.

The primary purpose of the hospital in parole is to further the treatment of the patient. This period represents to the patient a test of his ability to remain sufficiently well to

adjust in the community. He very frequently does not need the assistance of the social worker, but is able to resolve his own problems of social adjustment. For this reason not all paroled patients are under the supervision of the social-service department. They are theoretically under the care of the psychiatrist; cases are usually referred through him. Cases may be carried concomitantly by the psychiatrist and the social worker or by either. The services of other agencies are utilized when they are indicated.

The psychiatrist carries an over-all interest in the patient's rehabilitation, with emphasis upon his attitudes and mental symptoms. He refers to the social worker cases in which help is needed by the patient with his problems of social adjustment. The most frequent reasons for referring cases are: to assist the patient in obtaining employment; to help through a block in medical treatment, this usually in cases of syphilis where spinal or Wassermann check-ups are needed, or where the patient refuses treatment; to assist with the planning of his time, volunteer work, or recreation; to assist with legal, insurance, or Selective Service problems; and to help in contacts with other agencies. Cases remain active only during the period of actual case-work. They are closed when the service is completed, even though the parole period has not expired.

The coöperation of the psychiatrist and the social worker in their differentiated relationship to the patient is an important factor in his treatment. It helps the patient take the responsibility for defining the kind of assistance he needs, in as much as the use he may make of either one is limited. He soon learns that the social worker can relate only to his "well" self. The help of the psychiatrist is to be sought when his mental symptoms interfere with the resolving of his social problems. A patient uncertain as to the demarcation between his delusional and his oriented thinking may sometimes, through the interpretation of function by the social worker, gain real insight into his problem. At times a patient who is clinging to his symptoms may be helped by the psychiatrist's reference of his case to the social worker.

The decision to discharge from parole is made by the psychiatrist. This is based on the patient's ability to adjust

in the community without the continued protection of the out-patient department maintained by the state hospital.

Family-care placement implies a twofold responsibility for the hospital: first, to insure the welfare of the patient in the community, and second, to protect the community from any possible harm from the patient. Hence the procedures of family-care placement should be purposely impressive and carefully thought out, to accentuate the responsibility of each one of its principal participants. These include the physician, the social worker, the patient himself, and the care holder.

The physician is responsible for the reference of the patient and for the supervision of his therapy throughout the placement period. The social worker is responsible for the supervision of the patient in the community within the limitations prescribed by the hospital authorities. The patient has the responsibility of conforming to the conditions of his placement. The care holder is responsible for the patient's more immediate welfare and his behavior as a member of the community.

The patient to be considered for family care is first prepared for this step by the physician. The doctor discusses this measure with him in terms of his capacity to adjust in the community under specific conditions. These have been determined by the physician, in the light of his responsibility for the outgoing patient. He is then presented at the social-service staff meeting by the referring physician. This presentation constitutes the request for placement. It also defines the conditions under which the hospital will assume responsibility for the patient in the community.

The social-service staff meeting, presided over by the hospital superintendent, is attended by the department-head physicians and the staff of social workers. In presenting a case, the referring physician reads an abstract prepared specifically for this meeting. It stresses those factors which might present problems in the placement of the given individual. After this reading, the patient enters and is questioned first by the superintendent and then, in turn, by members of the group. The conditions under which his placement is being considered are discussed with him. Frequently these are modified as a result of his participation.

The outcome of the discussion may present several possibilities: the patient may refuse to accept the conditions imposed; the staff may reject present placement for the patient; or the placement may be tentatively decided upon. The patient then leaves the room. A general discussion follows in which a suitable plan is agreed upon, including medication and the advisable frequency of visits to the clinic. At the conclusion of the meeting, the patient is informed of the final decision. If his placement has been confirmed, he is told that a social worker will visit him.

For the patient, this staff presentation—as a part of the total process of treatment offered by the hospital—represents a crucial point in his progress toward community adjustment. At this meeting, the patient himself has an opportunity to express his reaction to the plan and to take part in its development. Before this meeting, no definite course of action had been prepared for him, because the plan resolved upon depends on the combined thinking of this professional group. The final decision is not one that is mandatory. It is one in which he has not only an opportunity, but a definite responsibility, to participate. This ability to participate affirms his confidence in his capacity to carry out the agreement. The authority that characterizes this meeting adds emphasis to the limitations which the patient must accept if he is to move toward family-care placement.

For the new worker, this meeting affords an invaluable learning experience. She gains through actual experience a knowledge of the psychiatric aspects of social case-work. The coördinated thinking of the two professions broadens her knowledge of mental illness generally; specifically, it gives her insight into the problem of the patient being presented. It also defines the limitations within which she must work. Her acceptance of these limitations not only confirms them for the patient, but relieves her of the necessity of coping with problems beyond the scope of her training. She is thus left free to work with the patient on a case-work basis.

To the psychiatrist, this meeting offers an opportunity for more responsible use of social case-work in the promotion of his own therapeutic aims. It has been the experience at Springfield that the psychiatrist also gains from this meeting

a better knowledge of the community resources. This helps him to visualize opportunities for other patients.

After the staff presentation, the case is assigned and the preparation for placement is begun. This probably constitutes the most difficult phase of the family-care process. Its success is dependent upon the social worker's ability to help the patient make it a realistic experience. To effect this, she visits him on the ward to discuss his plans. In ensuing visits she helps him toward a responsible acceptance or rejection of family care. While helping him resolve his struggle against the conditions of placement, she is faced with the problem of finding a home for an adult who must accept a situation not of his own selection. His is the status of a mental patient.

The new worker feels handicapped at first in trying to discover ways in which the patient can participate. Restricted as he is to the hospital grounds, he cannot take the responsibility for making community contacts which must be made in person. Gradually, however, the social worker learns that movement can be initiated in spite of the limited scope of the patient's activity.

Family-care placement involves much more risk to the patient than does parole to his family. Added to the insecurity he feels in leaving the protective environment of the hospital, he faces the necessity of adjusting in a totally strange situation, which, further, contains threat of hospital control. The depth of his reorganization while at the hospital is apparent in the degree to which he is able to handle this experience realistically.

In as much as family care is most frequently an intermediate step between hospital care and competitive living in the community, few patients placed in family care have reached the stage of recovery where this step can be taken without a real anxiety. Very seldom, however, are they able to admit their fears unaided. Even though the patient has requested family-care placement, he nearly always prefers to return to his own family. His first use of the social worker is to help him clarify his relationship with his family. He finds it difficult to accept their rejection of him or to admit changes in their situation or in himself that would

prevent his returning to them. Only through the pressure of his desire to leave the hospital does he gain courage to face the reality of his situation. In so doing, however, he becomes free to move toward an acceptance of self.

In her early contacts with the case, the worker usually finds that the patient's relatives have been unable to deal frankly with him. They have found it too difficult to admit to him that there is no longer a place for him in their homes or that they are afraid to take him. The worker finds a real problem here in helping both the patient and his relatives to take the responsibility for their respective parts in clarifying their relationship. This is usually begun by the patient through correspondence, which is followed by a visit to the relatives, by the worker. She interprets the patient's plan, clarifies their responsibility for stating the extent to which they are able to help, and explains the conditions under which the hospital will take responsibility for placement.

The necessity of facing this situation frequently brings about, in the relatives, a new interest in the patient. Eventually, or even before placement, this interest may lead the relatives to assume responsibility for the parole of the patient.

When the patient is finally able to accept the reality of his situation and is ready to take more concrete steps toward placement, the worker needs to meet with him and help him resolve any ambivalent feelings he may still foster in relation to this step. He continues to state his desire for placement; yet, belying this expressed ideal, he continues to project his insecurity in his need to control. This conflict can be resolved only as the worker is able to focus on the patient's desire to leave the hospital, holding constant the limitations within which they are free to work.

In locating a home for the patient, the worker is presented with the dual problem of finding a situation that the patient can accept, and of interpreting his needs to the community with such skill and understanding as to obtain the community's acceptance of him. While a member of the community might be loath to accept a "mental patient" in his home, he can relate to the needs of a particular person who is ready to leave a mental hospital, but who has no suitable home to which he can return.

The patient comes to accept a home through participating in this experience. The worker shares with him, step by step, the problems she is having in her efforts to secure a suitable placement for him. When possible, it is arranged to have the patient visit the home before placement.

Once an acceptable living situation has been found, the patient's emotional needs must be considered. The worker must find a home in which the therapeutic aims of the referring physician can be pursued. The worker translates the psychiatric limitations into social realities: she offers the patient a placement in which he can become one of a family group in which he will have a defined rôle. Once the rôle of the patient in the family group is clearly defined, the stigma of "mental patient" is removed. The care holder and the patient are now prepared to initiate a relationship that is natural since it has its counterparts in normal family life.

The following summary illustrates the application of this concept of placement. It also shows the progress of a worker new to psychiatric social work who, after only three months, was able to help the patient to enter so meaningfully into placement.

Margaret A. was admitted to Springfield on June 4, 1941, with a diagnosis of "personality disorder, the result of Parkinson's syndrome." Her difficulty seemed to date from the age of nine, following a fall. For a year preceding commitment, she had been irritable and assaultive, and had made abortive attempts at suicide. There was also stammering, trembling of the arms, and inability to complete an action when started.

She made a good hospital adjustment from the beginning. She soon became sociable and helpful with other patients. In spite of her tremors and rigidity, she was able to care for her personal needs adequately, and, under treatment, showed a decrease in her neurological symptoms. She gained twenty-five pounds and changed from a scrawny, repulsive-looking person to a very appealing, attractive girl.

In September, 1941, she was referred for family care, since her own family ignored the physician's request for her removal. At this time the family objected to placement, stating that they were planning to take her home.

On February 4, 1943, she was again referred for placement, her family still having made no plan for her. In working through her family's rejection with Margaret, it was finally revealed, through a sister, that although her father wanted to take her home, her step-mother refused to allow it, stating that she was afraid of the girl.

The family still objected to family care and refused to reply to the

letters sent by the hospital and the patient. It was, therefore, agreed that after waiting a specified time, the hospital would proceed with placement. Margaret was able to go along with this provision. When it became clear to her that she could not return home, she was ready to proceed with placement.

The recommendation of the social-service staff had been that she be placed in a protective home situation where she would be treated with warmth and affection, preferably where there were no children.

After considering several possibilities with Margaret, it was decided that Mrs. G. might like to have her. Mrs. G. was a motherly person who had a very comfortable home. She also had another patient, a middle-aged woman, living with her. Margaret liked the idea of going to Mrs. G.'s. She hoped that Mrs. G. would not mind her stammering and shaking. The following interview is the recording of the worker's visit to Mrs. G., February 19, 1943.

"Visited Mrs. G., who has a place for a patient. I informed Mrs. G. that Margaret was younger than the other patients she has had, but that her home might be very good for Margaret, as she needed to be some place where she would get love and affection. Margaret had been a personality problem in her home and she had been very difficult for her family to manage and at times would take a great dislike to one particular member. Since Margaret's stay in the hospital, she had been behaving very well, had assisted with the ward work, and was liked by every one. Because of the strain she had created at home, she probably was not wanted there and the family had not responded to letters written. Mrs. G., in her motherly way, stated that she could not understand how a family could treat a child like that, especially since they knew she was ill.

"I explained that the illness had left Margaret with a type of shaking similar to palsy and that, when excited, she showed this more markedly than at other times. Margaret stammered a great deal and did this more when she was excited. Mrs. G. said that she would not let this bother her as she had been around people afflicted this way and was certain that she could understand it. She felt it would be more like a home, having a younger girl around, and as she had no daughter of her own, she could be more like a daughter to her. I told Mrs. G. that this sort of relationship would be most helpful and was probably what Margaret needed very much.

"Mrs. G. said that she would like to discuss this with Mrs. W., the patient in the home. When Mrs. W was called in, she said that she knew who the patient was and that it would be company and a great comfort to have her here in the home. She also volunteered the information that if Mrs. G. could act as a mother, she herself could be the aunt of the family, and then Margaret would be sure to have a family to move into. I told Mrs. G that we would be able to pay her $24.00 per month and she agreed to this amount."

The worker visited the patient several days later to tell her about her visit to Mrs. G. She described in detail the family and the physical aspects of the home, including the room that would be hers. She told Margaret Mrs. G. really wanted her and thought that it would be like having a daughter in the home. Margaret was very enthusiastic about going, but needed the reassurance that Mrs. G. knew all about her

difficulties and did not mind at all. It was decided that the worker could take her on February 26, 1943.

Two days before that date, Mrs. G. was again visited, and the final arrangements for Margaret's arrival were made. The following are excerpts from the placement interview:

"Moved the patient to the home of Mrs. G. Margaret said on the way there that she had been so excited about leaving the hospital that she had been unable to sleep and hoped that she could take a nap in the afternoon. She was quite interested in the countryside and mentioned how different this was compared to the mountains around her home. She felt that she would be able to see more across the landscape. Driving farther down the road, she spotted the house with its red shutters and said, 'There it is!'

"Mrs. G. greeted the patient cordially and seemed quite pleased. She showed Margaret to her room and then left the worker with her. Margaret said that she was so excited she was stammering entirely too much, but was trying to talk slowly, so that she wouldn't sound too unintelligible. She seemed quite pleased with her room and said she would wait until I left before she put her belongings away.

"We all spoke together and Margaret told Mrs. G. that she had her medicine with her, but that she did not have to be reminded to take it. Mrs. G stated that she would watch her to see that she did not skip it. Mrs. G. told Margaret that she was so happy to have her in the home and because of her she had acquired a daughter and was very pleased. Margaret said that she would try very hard to be a good daughter."

When a patient is placed in family care, the care holder is required to sign a form which defines her responsibility to the patient and to the hospital, and the hospital's responsibility to the care holder and to the patient. It describes the patient's status in the household and the extent to which he can use freedom. If the patient is placed on a working basis, it delineates his duties and states the remuneration agreed upon.

Within the limitations described in the placement form, which varies with each case and which is subject to modification by the out-patient psychiatrist, the patient is free to live as a member of the community. He may live in several situations during the placement period, the changes being initiated because of dissatisfaction on the part either of the patient or of the care holder, or because of his ability to assume greater self-responsibility.

Family care may be terminated by discharge, parole to family, or return to the hospital. If the patient becomes dissatisfied with the control that the hospital exerts over him, he may return to the hospital, have a responsible relative or

friend assume responsibility for his parole, or request discharge, which may be granted at the discretion of the psychiatrist.

The patient is visited once a week after placement and once a month routinely until the end of the placement period. However, if the parole is renewed for the second year, the visits are reduced to every three months, unless problems arise that necessitate more frequent visits.

This arrangement has value both for the worker and for the patient. It enables the worker to help the patient face placement not in terms of a year, but from month to month, so that practical realities of living are worked with. Problems are met step by step, and in meeting them, the patient gains increasing confidence.

Partializing the placement period affords the new worker a parallel experience. She is overwhelmed with the totality of the responsibility of finding her relationship to the patients in her care. Under this arrangement she is able to see movement, since her patient in the seventh month is not the same as he was in the third month. By concentrating her energies in the present, she helps him meet the future steadily and with growing security.

The arrangement has a further value in that by providing a report of the patient's condition at stated intervals, it helps the hospital carry out its responsibility for him. At the same time it minimizes the patient's fear in this connection since he knows that monthly visits are required in all cases and do not apply specifically to him. The support that the patient gains from this knowledge frees him to make more responsible use of the case-work assistance offered him.

The case summary that follows illustrates the use that the patient was able to make of family care to achieve growth. He was enabled to assume his responsibilities in an adult manner and was thus relieved of the necessity of remaining ill.

> Lloyd W. was admitted to Springfield at the age of thirty-one, an intelligent neurotic—occupation, clerk. After six months he was paroled to his wife, condition improved, and returned to his old job. He was seen in our out-patient clinic and referred for treatment to a private psychiatrist. After several months he had to return to Springfield, unable to live up to his responsibilities.
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> A year and a half later, he was referred, just as sick, for social

planning by a hospital psychiatrist, who had given him intensive treatment by analytic methods. The following is the psychiatrist's comment upon the case: "Feel we cannot help here because of environmental difficulties—namely, mother and wife and both families. Wife has opportunity to get husband a job as caretaker with maintenance. Suggest they be permitted to work out their own problem. See no further need or value of hospitalization."

The wife, an emotionally dependent person, was living with her two children in her mother's home and was partially dependent upon her family, having a part-time job. Her family was antagonistic toward the patient.

The patient's mother, on whom he was emotionally dependent, was interfering and antagonistic toward the wife. The patient had three alternatives in leaving the hospital—his sister's home with his mother, separated from his wife and children; his wife's mother's home, where he was not wanted; or the caretaker's job, which was most distasteful to him. Family care was suggested by the outpatient psychiatrist.

Now the problem as seen by the psychiatrist was to help the patient accept assistance in finding a situation on a level that offered security and freedom from the pressure of responsibility until such time as he could gradually, in a more normal environment, work through his problems of adjustment.

With limitations considered advisable by the psychiatrist, the social worker worked through placement with him in a boarding situation in Baltimore, in the home of a middle-aged couple, the wife being a protecting, motherly person. His wife had been referred to a private family agency, where she was able to obtain assistance in establishing her own home, thus relieving the patient of the responsibility and sense of guilt inherent in his wife's dependency on her family.

As soon as he was relieved from pressure, this neurotic, with psychiatric guidance and social case-work assistance, worked out his problem. Almost immediately upon leaving the hospital, on his own initiative, he sought odd jobs as a painter, working first for Mrs. J., the care holder. By the end of six weeks he had obtained regular employment as a painter in the shipyards and after five months in family care returned to his old job at the B. & O. Railroad. Within the next two months he had received a promotion, made a down payment on a house, and had reëstablished his home. He was then discharged from family care, since he was no longer living in a placement situation.

The home in which this patient was placed met his particular needs in that the care holder represented the sustaining type of mother symbol to whom a dependent neurotic could relate, yet move from toward adjustment. The greatest problem encountered by the worker in her relationship to the patient centered in his struggle to accept responsibility for his financial support. Although he informed the worker, with pride, of his prospective job at the shipyards, and agreed

that after his first pay he would no longer need financial assistance from the hospital, it was discovered a month later that he had not paid his board. When this was discussed with him he offered no logical reason for not meeting this obligation, but stated that he was trying to save his money and had seventy-three dollars in bank. When faced by the worker with the necessity of meeting his indebtedness, he refused to draw his money out of bank, but was able to make his own arrangement with Mrs. J. whereby he paid a part of the money he owed along with his board each week.

The patient's reluctance to pay his board to Mrs. J. seemed to be entirely dissociated from his recognition of his financial responsibility, but seemed to symbolize his fear of becoming emotionally independent of Mrs. J., because in separating from her he would be achieving separation from his mother. Once this obstacle was overcome, he moved rapidly toward the acceptance of responsibility for himself and for his family.

Although ending is always present as an integral part of the placement process, it is brought to a focus by the worker in the tenth month in order that the patient may have an opportunity to participate in the evaluation of his experience and to take responsibility as far as he is able for his next step, whether it be discharge or an extension of placement for another year. A final evaluation is made by the physician who sees the patient in the eleventh month, and makes his decision on the basis of the social worker's report and his impression of the extent to which he feels the patient is able to take responsibility for himself.

To be considered ready for discharge, the patient must be capable of making and carrying out his plan for living as a responsible citizen in the community. He may be self-supporting or financially dependent, either upon private resources or upon a social agency. If he is unable to plan for himself, but can live in the community under supervision, he may be discharged in the custody of a responsible relative or he may remain in family care.

This framework, with the definite conditions that it provides, not only helps the patient approach the ending of placement realistically, but also affords a support for the

inexperienced worker, helping her to define and to operate within the area of her own responsibility. The patient who is ready to leave anticipates the final step and sees the end of placement as a goal toward which he is moving. Many patients, however, who find leaving difficult, are able to make use of the time element in ending as a limitation against which they must strive if they are to achieve discharge.

Discharge as the final step in the family-care process is a dramatic experience in the life of the patient. The recognition it implies confirms his own growing self-confidence in his ability to be released from hospital control and to become once more a free and responsible citizen. He approaches discharge in much the same manner in which he approached placement, but having successfully overcome his fear in taking that first step, he is now able, with increased confidence and the aid of the social worker, to recognize the similarity of the two experiences and to apply the knowledge he gained in the former to help him cope with the new insecurity he is now facing. The social worker, in helping the patient to make discharge a meaningful experience, is preparing him to meet other life experiences with some understanding of his own involvement in them.

The following case illustrates how a patient was helped to take responsibility in effecting her discharge from family care, and the use she made of the time limit in family care.

> Anna H., a fifty-one-year-old minister's wife, diagnosed paranoid condition, who was separated from her husband as a result of her mental illness, came for her appointment with the worker to discuss her financial situation, since her discharge from family care was dependent upon her ability to arrange for her own support. The psychiatrist had told her a month before that she was no longer in need of supervision and was competent to make her own plans. There now remained only three weeks and two days before the date of her discharge, and she had been unable to carry out her plans for support.
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> The hospital was supplementing the ten dollars a month that her husband was grudgingly giving toward her board. He stated that he was contributing all he could spare to the support of an ill son. The patient had tried to verify his salary, but had been unsuccessful because she was afraid that any action on her part might jeopardize his appointment, since he was still in his probationary period. Mr. H. had stated that he would be willing to assume financial responsibility for Mrs. H. in three months, as his appointment would then become permanent and he would get an increase in salary. The hospital was

willing to extend the placement period and continue with financial assistance until the problem of the patient's support could be settled.

Mrs. H., however, was eager to be discharged, stating that the discharge date was her birthday and that discharge would be the best birthday present she could imagine. She did not trust her husband's integrity and she planned to bring pressure to bear upon him through a church official whom she could trust. She also planned to ask her daughter's assistance for the two intervening months. She had expressed these intentions several times before, but had done nothing about them. The social worker had felt that she was trying to shift the responsibility for making these contacts to her and had consistently made it clear to Mrs. H. that she would have to take responsibility for handling this problem. The worker recognized with her how much she wanted discharge, yet how difficult she was finding it. Mrs. H. then began discussing her experiences in family care, stressing how frightened she had been in anticipating placement and how everything had gradually worked out all right. She ended by stating that she planned to take definite action regarding her present situation within the coming week.

When she returned the following week, she was quite changed and confidently stated that she had seen the church official, who had assured her that her husband was receiving an income sufficiently large to provide for her support, and that he would make an appointment to discuss the problem with Mr. H. Mrs. H. went on to say how much better she felt, and that she planned to get a light-housekeeping room where she could cook her own meals and have a few of her own things around her. She thought she might even earn a little money by taking care of children in the evening. She said she had to get her financial situation straightened out in a hurry and that the worker would be surprised to see how much she could do to help herself, now that she had got started. An appointment was arranged for the following week.

In the next interview, she had made no further progress. She had been unable to see the church official, but planned to try again.

Mrs. H. returned the following week, three days before the expiration of her placement. She had taken no further steps toward securing support and her situation in this respect was unchanged. She was less antagonistic toward her husband and expressed again her reluctance to do anything that might jeopardize his position. She did, however, still want to be discharged and wanted to discuss other possible ways for obtaining support, as her daughter could not help her. The possibility of asking assistance from the Family Welfare Association was suggested. She then remembered that she might be able to secure help from a church fund of which she had knowledge, and stated that she preferred to investigate that first. When she left, she said that she would inform the worker in a day or so of her plans.

She telephoned late that afternoon, quite elated. She had learned that she was not eligible for assistance from the church fund, but after discussing the situation with her daughter, she had decided to make her application to the Family Welfare Association the next day.

The following is an excerpt from the record:

"A telephone call was received from Miss L. of the Family Welfare

Association regarding Mrs. H. who had made application for assistance. Mrs. H.'s situation was discussed at length and Family Welfare Association decided to give her financial assistance until something could be worked out with her husband. A conference was arranged for March 30th.

"Later Mrs. H. called to state that Family Welfare Association had agreed to help her. The worker had been so kind and tactful that she had 'just gone ahead and told her everything.' She also had wanted her to know how much we had helped her and had referred her to us for further information regarding herself. She said that she was so glad to have 'graduated,' but would miss seeing us. She had already found new living quarters near her daughter and was preparing to move from 'Mrs. B.'s finishing school' at the end of the week."

By placing the responsibility upon Mrs. H. for resolving the problem of her financial support and helping her express her fears around placement, she was helped to accept discharge as a meaningful experience. In the struggle against the time limit created by the discharge date, she was able to resolve her conflicts and move toward the affirmation of her new self and the reality of her situation.

I have presented the definition and scope of social casework as an integral part of the total function of a state mental hospital. In order to do this, I have given my concept of the social structure of the institution and the meaning of the hospital experience to the patient. I have also described some of the problems of the new worker in her adjustment to institutional living as well as to a new job. The fact that family care is her main focus plays its part in helping her to orient herself in relation to her purpose in the institution and in relation to the patient and the psychiatrist. Although family care is not always the center of her working relationship with the patient, from the beginning it is the constant factor. If it is steadily held to, she cannot help but see the patient as having a normal side to which she can relate.

The need for family care and for sound social-work practice in state mental hospitals is steadily gaining recognition throughout the country. Through family care, social work for the first time has been able to define itself in the mental-hospital setting as essential to its operation, yet different from psychiatry. From this nucleus of security, social work is able to develop its skill. With the expansion of family care has come an increased demand for workers, higher salaries,

and an interest in skill. These changes have resulted in greater professional recognition, and a reintegration of the total service.

I believe that the integration of the family-care function into the state-hospital program marks the end of the pioneer period of social case-work in this field, and the beginning of an era in which sound professional development can take root. It is the point at which social case-work is able to separate from the psychiatric function and begin to exist in its own right.

MORALE AND THE ATTENDANT

A NOTE ON PERSONNEL PROBLEMS IN HOSPITALS FOR THE MENTALLY DISORDERED

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THE organization of ward care in any modern hospital for the mentally disordered depends, finally, on the relatively untrained attendant. In the average state hospital, even those attendants and trained nurses who are in charge of wards, performing at least partially administrative work, have had little psychiatric training. There is always a large turnover in attendants, and now, with the general shortage of man power, the attendant problem is one of the most acute of those that confront the hospital superintendent.

It is obvious that the relative rate of turnover is dependent on, amongst other things, the morale of those concerned. Anything that increases the morale of the attendant body will tend to reduce turnover. The critical shortage of hospital personnel certainly demands attention to this problem. The thesis of this paper is that morale can be increased by enabling the attendant to understand his work better and that efforts toward this end have been rewarded by higher standards of psychiatric care.

A program for morale building must start with a study of the people concerned. Attendants in hospitals for the mentally disordered are not a particular, special group of human beings, different in a significant way from all others—they are a miscellaneous cross-section of the population. The characteristics of many of these attendants are determined by the interaction of two sets of factors. One of these is notorious, so much so in some hospitals that the other is completely ignored. This is the set of factors associated with the relative lack of economically remunerative skills that many attendants show, and that often leads to attendants' in general being unjustly considered inferior in character and stability.

The other set comprises those factors of personal history which make the care of the mentally ill, however exacting it may be, an attractive life work. Attendants actuated by this set of factors, while not in the numerical majority, are individually of the greatest value to the hospital, whether this value is realized or only potential.

According to the usual set-up in a modern hospital, attendants are supposed to have the duty of carrying out the doctors' orders, with little of their own personalities entering into the situation. On the other hand, the contacts between the physicians and the patients are so short and few that it is the attendants rather than the physicians who interpret the hospital to the patients. Since this physician-patient relationship falls far short of fulfilling the patients' needs, and the attendants are not trained to handle their relationships with the patients, the physician-patient relationship may be said to be replaced by a hospital-patient relationship. Whatever security the patients may feel rests, not upon a personal relationship, but upon the hospital structure as a whole. The interpretation that the attendants present to the patients may be important from a treatment aspect. If the morale of the attendants is good, it may well be that their value to the patients is measurably increased.

Probably the most important single element in the morale of the individual attendant is his confidence in his ability to do a good job, and the knowledge that this ability is recognized by the physician. Proper training is of importance in the attendant's performance of his work, but in the courses given attendants there is too much of a tendency to emphasize the physical care of the patient rather than an understanding of him as an individual. Therefore, as the attendant's job is at best a difficult one, he will tend to carry on this emphasis, and come to look upon the patients merely as nuisances, or as possessing no more individuality than so many sheep. They will be expected to conform to a certain pattern, one that represents the least amount of trouble to the attendant, suppressing any expressions of their own personalities.

The patients who do not conform will be punished either by direct physical abuse—which an artful attendant can exercise to a surprising extent unnoticed—or by scolding and an

overriding of their wills by means of shouting and commanding in definitely unsympathetic tones. The latter may well be the more pernicious method of the two, as it leaves the patients with no good basis in their own minds for reacting with anger against the attendant's onslaughts, and this only adds to their feelings of inferiority and guilt. To remind the attendant, however often, that abuse will be severely punished may make the situation worse, as, knowing no other way to handle the situation, he feels defenseless against the attacks of disturbed patients.

Another serious result of the attendant's abuse is that he may come to stand in constant fear of discovery, which impairs still further the working relationship between him and the physician.

If the physician fails to recognize his responsibility in keeping up the morale of the attendant, and looks at him only in terms of the menial labor he performs in the physical care of the patients, disregarding his need to put his personality into his work, the result will probably be that the attendant will feel not only left out, but actually rebuffed. Almost certainly resentment is bound to arise in him against the physician, and some, at least, of this resentment will find an outlet in abuse of the patients.

It follows, then, that one way in which the physician may increase the attendant's morale is, in dealing with him, to recognize his proper function. This, in turn, will lead to the attendant's being able to recognize his responsibility toward the patient. The attendant will be helped to feel that he has a place in the organization and something of value to contribute if the physician shares with him as much as possible of the responsibility for running the ward by frequently consulting with him, and often, in fact, leaving up to him decisions for the management of the patients on the ward. It will inspire in him pride in his work and a feeling of working with the physician toward alleviation of the sufferings of his fellow men.

The physician should determine general policies, and then discuss these with the attendant along with the decisions that the attendant makes from day to day, so that the attendant will feel the continued interest of the physician. At the same time, the reasons for the attendant's decisions should be

discussed, together with the mechanisms behind the patient's behavior.

The discussion of these mechanisms gives the attendant an understanding of his work and is thus another important factor in building up his morale. The psychiatry presented in the training course of the average hospital is of a descriptive nature, generally including little explanation of mechanisms. But whatever is included, no actual realization of psychiatric mechanisms can be achieved without frequent reference to actual cases. Therefore, repeated discussions, on the ward, of situations as they arise, with special emphasis on the probable reasons why the patients react as they do, are indispensable. It may be pointed out to the attendant that many of the reactions the patients show, either to real or to imaginary difficulties, are similar to those considered typical of childhood, and that the attendant, by referring to his own early past experiences, may gain a better understanding of the patient's behavior.

It is through this attempt to gain understanding that those attendants whose attraction to jobs among the mentally disordered arises from factors in their personal history can secure the maximum benefit from their work and, in the process, can be of most help to the hospital. This group of attendants are those who have somehow felt, however dimly, that difficulties in their lives may be due to poor social techniques arising from early accidents in the emotional sphere. They feel an insecurity that leads them to seek to study those whose emotional balance has been completely upset. Discussion of patients with the physician leads them toward the very information that they seek. Their emotional impetus to follow that lead by conversing with the patients brings them to a much better understanding of the patients' thinking, and enables them to accept the patients as perhaps not so queer, after all. The value to the hospital of attendants with such feelings toward the patients can hardly be overestimated.

In order to participate in a program of better placed responsibility, the physician must familiarize himself with the principles that govern interpersonal relationships. His attitude must be one of real understanding and respect for the attendant. Otherwise, he can never communicate to the

attendant the ability to feel such respect for the patient. As it has been the practice to draw our attendants from a low economic and educational level, the physician may feel that he cannot respect such personnel. But understanding of the emotional problems of others, and ability to profit by the training here indicated, are independent of education and economic status.

The rather ineffectual rôle of the attendant is much less the result of educational and financial lacks than of the insecurity of the physician. The physician may feel that by increasing the attendant's responsibility he may reduce his own importance in the hospital constellation, and breed disrespect for his own opinions. This is not so, because giving the attendant an opportunity to contribute something of value will enable him to be freer to consider the opinions of his superiors. If the physician's attitude is not genuine, the attendant will be quick to divine this.

The use of such forms of restraint as lock-chairs, camisoles, and so on, may be carried to an excess when the number of ward attendants has been reduced. If, however, the attitude of the attendant is one of wholehearted interest in the patient, he can be depended upon to handle difficult situations in such a way as practically to eliminate the need for restraint.

The following incident is an illustration of the benefit to be gained by giving more attention to the attitudes of attendants. It came to our attention that a certain attendant on one of our disturbed wards was mistreating his patients in a deplorable manner. It happened that I had certain common interests with this attendant, and in other respects I had always found him a friendly person, and had been of the opinion that he was an excellent, efficient man. To all appearances he did his work well, and when asked about any patient at all on the ward, he could give a prompt and, as far as could be determined, accurate answer. It was rather distressing to hear about his mistreatment of patients, but as our source of information was unimpeachable, I was forced to give credit to it. At the same time, it was for certain reasons impossible to use this information as a direct accusation against the attendant.

The decision was made to wait until usable evidence against

him appeared, but I felt that I could use my friendly relations with him to bring about an improvement in his attitude toward the patients. As he was the charge attendant, during the course of my work on the ward I found it possible to pay particular attention to him. Whenever he came to me with a problem that concerned the patients, I went over it with him carefully, in all its aspects, giving ample consideration to his opinions, explaining, as far as possible, the patient's behavior, attempting to rationalize it so that he would be able to look upon it as the behavior not of a bad boy, but of some one acting in accordance with impulses and ideas that, though they seemed ridiculous to the attendant, were real and extremely important to the patient.

At the same time, I pointed out ways in which he could elicit information from the patients and satisfy himself regarding some of the interpretations I had given. He seemed interested in this, and soon was offering his own findings in the cases we discussed in comparison with mine. I always showed great interest in his findings, stressing the fact that he had discovered these things for himself, rather than the question of accuracy. I was not, of course, unmindful of the fact that the attendant might be paying attention to me merely because he felt it to be part of his job, but from an objective point of view I felt that I detected sufficient evidence of genuine interest.

After I had been pursuing this course for over a month, during which time, in order to evaluate my results as accurately as possible, I had refrained from mentioning my experiment to any one, I again sought out my source of information about this attendant and said to him, "I want to discuss with you A's roughness with patients." With no further word from me, my informant replied, "Oh, there's been quite a change in him recently. One of the other men and I both have remarked it. Now, upon placing a patient in the lock-chair, instead of slapping him a couple of times, he talks to the patient, explains to him that we are trying to help him, and frequently gains the patient's coöperation. His attitude in other situations, too, has changed."

I feel that this evidence, given voluntarily, with no knowledge of what I had been doing or what I had expected to discover, is ample proof, not perhaps that I have completely

reformed this attendant, but that I have succeeded at least in some measure in bringing about a softening of his attitude, a sufficient justification for carrying the experiment further.

I have purposely avoided offering any set plan for carrying out the ideas here propounded, as the procedure must be based upon the specific situation and the personalities involved. Essentially, the attendant must be given a chance to discuss with the physician his feelings toward the patients without censure, thus coming to realize that feelings do enter into the handling of patients.

If and when the practical importance of morale in the attendant body is recognized—and well-directed efforts in this direction are being made—it may appear that quite a new conception of mental-hospital-personnel organization is emerging and that we are moving toward the creation of an entirely new class of ward worker.

SOME FEATURES OF THE EMOTIONAL RESISTANCE AGAINST THE PSYCHO-ANALYTIC APPROACH IN SCHOOLS

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THE great hopes that psychoanalysis in its initial stages held out for the development of a fundamentally new educational technique have been realized only to a small extent, partly on account of an attitude of distrust and rejection on the part of the schools. In the following paper I shall try to analyze some of the more significant expressions of this defensive attitude.

Schools are social institutions. They represent the standards and values of the people who maintain them. Public schools in a democratic country, therefore, represent the ideas of the average parent as to what education should be. They cannot afford to have educational standards too far behind or too far ahead of those of the average parent. This means that psychoanalysis, like any other innovation, will be accepted in schools only when the average parent becomes convinced of its worth. Consequently, parents, teachers, and administrators should be persuaded of the usefulness of the psychoanalytic approach before it can be introduced in schools. This seems a big task, for each of these groups will develop certain group resistances besides the general one that psychoanalysis arouses by its very nature.

Parental resistance can be studied most clearly in the case of parents of difficult children. Parents of problem children experience the dread of psychoanalysis as an immediate danger more intensely than others. The very word psychoanalysis conveys to them associations of insanity and the sanitarium. The activity of the psychoanalyst has an uncanny connotation for them. Frequently, such parents show a nervous fear that some damage may be done to the child during treatment—that his mind may be pulled to pieces, and similar strange ideas. This anxiety is often repressed into the unconscious, and in such cases it may be combined

with a conscious theoretical enthusiasm for psychoanalysis. Some parents seem to have a feeling that everything is right as long as the child can be kept away from the psychoanalyst, and that everything is wrong once a psychoanalyst works with a child.

Jealousy is another reason for parental resistance. Some parents are afraid that the psychoanalyst may get a strong emotional hold on the child, thereby estranging him from them. This fear is particularly intense in cases where the parents themselves are emotionally too strongly bound up with the child, and resent any loosening of this emotional tie. This jealousy will rarely be shown openly, but the analyst often feels that it works against him as a powerful underground force.

Again, parents often develop a strong feeling of guilt that complicates the problem. They feel somehow responsible for the difficulty of the child, either because of his constitution, or because of mistakes that they may have made in his education.

Anxiety, jealousy, and sense of guilt are often the unconscious causes of the resistance of parents to the treatment of their children and to the help that psychoanalysis could give. The thought that the child may be disturbed not only activates guilt sense and anxiety, but also deals a deadly blow to the pride of many parents. Small wonder, therefore, that they defend themselves against acknowledging the child's disturbance to the last and by every means. Sometimes, the parents unconsciously feel that the child's disturbance is only a part of the whole disturbed situation at home, and that any change in the child would affect themselves. In that case they defend their own neurosis along with that of the child.

For all these reasons, parents meet with distrust the person who tries to rid the child of the disturbance. Often they follow the process of cure only reluctantly. Their resistance is rarely open and conscious; usually it is unconscious and well rationalized. When they reject the psychoanalyst and his help, it is never their own neurotic anxiety that they are defending, but the inadequacy of psychology that forces them to be cautious. Is there, indeed, any com-

monly acknowledged scientific doctrine in psychology? Do not even the psychologists themselves argue about the most fundamental principles of their science?

Sometimes it is the person of the psychoanalyst who repels the parents. There are, of course, more or less agreeable psychoanalysts, as there are more or less agreeable other people. This dislike, however, does not so much apply to the person of the psychoanalyst as to the dangers that may result from his activity. That this is so is most readily seen in cases where the aggression against the psychoanalyst appears before parents even have met him.

There are other parents who consciously are ready to coöperate fully. Their zeal sometimes seems exaggerated. They ask for strict prescriptions, and they are ready to comply with all suggestions. They study psychological books, attend lectures, like to discuss psychological questions, and, when they are rich enough, they even found schools. In these cases the parental resistance has withdrawn further into the unconscious, and appears only if a truly inward, not a merely external, change of attitude is demanded. What these parents are aiming for is an alibi. They want to transfer responsibility from themselves. They constantly ask for external prescriptions with which they comply eagerly. Having complied with them, their conscience is at ease. If the prescription has not helped, that is not their fault, but the analysts'. But if one of the prescriptions really touches the sore spot of the relationship between parents and children, then their enthusiasm to coöperate disappears, and their underlying resistance comes to the fore.

The disguises behind which parental resistance hides are so manifold and so intricate that they defy description. One of the most critical forms is the absolute indifference that seeks to divert all attempts at influence. But in whatever form the resistance of the parents appears, it is a regularly accompanying feature of each case, and it must be reckoned with from the beginning.

It would be a mistake to assume that only parents of particularly disturbed children show signs of this emotional resistance. There are traces of it in most parents, though these are not easily recognizable, as they are mostly kept

in the unconscious. But, on the whole, parental resistance is a very important factor that must be reckoned with in every school.

The resistance of the teachers is of a more intricate nature than that of the parents. It can be understood only by considering the socio-psychological function of the teacher within the school system. I leave aside the problem of the neurotic teacher who must oppose psychoanalysis in self-defense.

The function of the teacher is to act as a father or mother substitute for the child at a time when he is ready to transfer those patterns of feeling and behavior which he has established within the family circle to people outside of the family. He will then react to the person of the teacher in about the same way as he reacted to his father or his mother. This transference of feelings explains many otherwise inexplicable reactions. Hatred, fear, rebelliousness against the teacher, but also submissiveness and devotion are often only repetitions of corresponding behavior patterns at home.

This transference of feelings enriches the teacher's emotional life. It is the source of the highest and finest professional satisfaction. If the teacher, in the case of a disturbed child, has to seek the analyst's help, she suffers at least a partial loss of the child's emotional transference. For the analyst will now step into the teacher's place as the father or mother substitute. This process depletes the teacher's emotional life; it is experienced as loss of love and is resented accordingly. In extreme cases, this resentment may even be expressed openly in the form of jealousy. Mostly it is only a very dim feeling, or it remains completely in the unconscious.

One of the ways of avoiding this emotional loss for the teacher is for her not to refer her problem to the psychologist who works at the school. I know from experience that there are some teachers who simply cannot refer a difficult child to some one else. But they act quite unconsciously.

Having to refer a child to an expert not only entails loss of love, but often activates hidden inferiority complexes in teachers.

The teacher's function in our schools is to care for the intellectual achievement and the social and moral adjust-

ment of her pupils. She does this by upholding the intellectual, social, and moral standards of the community in which she lives. This presupposes that these standards are of vital importance to her, or at least that she is deeply interested in them.

Our standards are built up in earliest childhood by parental authority. It is the parents who first limit and frustrate many of our instinctive wishes. Later, the teacher takes over this parental function, and finally society itself. If some one feels drawn toward a profession whose essential psychological function is that of representing parental authority and limiting emotional impulses by upholding standards and the claims of conscience, we are entitled to conclude that this function has a particularly strong emotional appeal to the individual in question. Taking over the rôle of father or mother, possessing parental authority, having the power of praising or blaming, rewarding or punishing, must have been of high emotional importance to such a person as a child. These were the rights that she most envied her parents when she was little. They were so important to her that it became her life aim to attain them.

By identifying herself with her parents, she treats her pupils in the same way in which her parents have treated her. If her attitude toward her parents was antagonistic, she will sometimes strive to undo in her pupils what her parents did to her. This is the reason why teachers who had a hard childhood often try to be particularly kind and understanding to their pupils, or why others who come from conservative families and formal schools develop extremely progressive views on education. But whether by doing or undoing, by imitating the parental authority or by revolting against it, the teacher will, unconsciously, act under the influence of this parental authority, and as this dependency is unconscious, there is no escape from it by ordinary means.

The teacher is, very generally speaking, often a person whose unconscious dependence on the authorities of her own childhood is particularly strong. Her way of attaining independent status is to assume parental authority in her work. This work is, from an emotional point of view, a constant revival of her own parent-child situation and an

attempt to solve the conflicts involved in it. She assumes the position of the parent in her relations with her pupils, and the position of the child in her relations with her superior, and tries to demonstrate in both relations her idea of what a parent-child relationship really should be. Actually, she often only repeats the conflicts of her earliest years of life, and in some cases, her work may become a continuous, repetitive, compulsory attempt to solve her own unresolved parent-child situation.

When the teacher assumes the parental position in her work, she rarely does it consciously. This act is an unconscious gratification of infantile wishes, recognizable as such by the feeling of pleasure that it produces. As the whole process is unconscious, the rules of reality and logic do not apply to it. The parent whose position the teacher tries to adopt is not identical with the real one, but with the parent image of her own childhood, with the father and mother as she experienced them when she was quite young. This parent image shows father and mother not only as the most powerful, but also as the wisest and best people on earth. In striving to take their place, the teacher must strive for their qualities. This means that there will be a marked perfectionistic tendency in teachers, a strong unconscious wish toward intellectual and moral perfection. Such wishes are, of course, not limited to teachers; they are common to mankind. But it seems as if they were more recognizable among the teaching profession. Such wishes can be the source of the highest professional achievements. But when strongly marked, they will render a person also particularly sensitive to frustrations and disappointments in the intellectual and moral field.

Much in the school set-up makes the teacher feel most powerful, very wise and good. Her views are laws in her group, and she is constantly surrounded by those who are intellectually her inferiors. This may foster an unrealistic feeling of superiority. As so many external circumstances of her work favor her strong unconscious wish, one should not be greatly surprised if the teacher now and then succumbs to the temptation of confounding her wish with reality.

Failing with a pupil, having to apply for the help of an

expert, is certainly a frustration of the wish for power and intellectual perfection, and the teacher will always experience it as such. Particularly younger teachers who try hard to prove themselves adequate to any emergency will feel wounded and dejected when confronted with cases with which they think they have failed. The expert who takes over the treatment of the child, therefore, not only deprives the teacher of the child's love, but also stands in the light of her wish for perfection.

Whoever works as a child-guidance expert in schools recognizes this unconscious hostility, the expressions of which are often negligibly small, but always indicative of the same underlying emotional trend. It is natural that the most unpromising cases are referred to the expert, but the mood of malicious expectancy in which this is sometimes done is characteristic. Teachers agree readily that a lasting change in an individual requires much time. They are, nevertheless, apt to become impatient when after a few weeks or months no fundamental change in the child is recognizable, and to interpret prematurely the long duration of a treatment as failure.

Teachers register the failures of an expert as well as his successes, and sometimes the former more eagerly than the latter. They may consider a partial success a failure, and a full success only a partial one. In the case of an undeniable success, they may attribute the change in the child to all sorts of external occurrences in his life, to his growing up, or to a change in his environment. They feel that the child would have changed for the better anyhow, even without the analyst. As it is impossible to prove what would have happened to the child without treatment, anything that the analyst does can easily be questioned on this basis.

What complicates the position of the analyst further is the fact that there is no real place for him in the set-up of the school. He is not accorded full parental authority, but it is also not easy for the teacher to accept him as a fellow staff member in a brother-and-sister relationship. He has an in-between position. He certainly possesses one attribute of the father authority—greater knowledge in a

matter of essential importance in the educational process—but he does not possess the actual power or authority of the principal or the superintendent.

So far as the teacher accepts the analyst as a father authority, the relationship will again be determined by the teacher's feelings for her own parents. These feelings may range from respect and love to anxiety and hostility, and the expert will occasionally get his share of all of them. Once the teacher accepts the expert emotionally as a father authority, she is likely to renew unconsciously her wish for a perfect—that is an all-powerful and infallible—father image. In this connection any failure of the expert to live up to such standards becomes a disappointment quite out of proportion to reality.

Sometimes the rejection of psychoanalysis and psychoanalytic training is justified on the ground that not so much academic knowledge and training as sound common sense and a certain natural aptitude for understanding people's conflicts is needed to cope with their emotional difficulties. In other words, everything depends on the personality of the adviser, rather than on his training and technique. Examples are cited where trained experts failed and untrained people succeeded.

This view contains a partial truth. The personal qualities of anybody who deals with human relationships are certainly of the highest importance, and there are quite a few untrained people who, by means of their harmonious, well-balanced, and understanding personalities, will be more successful than certain trained experts whose aptitude for their profession is poor. But to put the problem in this way is an oversimplification that clouds the issue. A harmonious, well-balanced individual who is able to put himself imaginatively into other people's emotions and affects, who possesses an intuitive knowledge of the nature of the unconscious, who is energetic enough to intrude into strange relationships and to cope with the resistance of parents and children, will not be found often. Such a combination of qualities is a lucky coincidence wherever it occurs. But we cannot build the future development of child guidance in schools on lucky coincidences. We must have a plan and a system. Psychoanalytic training greatly improves any

person's propensity for this kind of work, and those who have a natural aptitude for it will profit by such training most of all.

The view that only the personality matters and that psychological training is superfluous is a misleading half-truth. To accept it would mean to bar progress in the field of mental hygiene and child guidance in schools, to leave the whole development to chance. Sometimes this view serves as an unconscious escape mechanism, for whoever holds this opinion needs not bother to acquire more training and knowledge in an obviously very large and complex field.

From the foregoing it follows that the personal attitude of the principal of the school is of the highest importance for acceptance or rejection of psychoanalytic methods in his school, not only because the teachers are, to a certain degree, dependent on his views, but more because of their unconscious dependence upon him. The principal is the teacher's parent substitute. He activates the friendly and antagonistic feelings that they have experienced in their relationships with their parents—love and admiration, hatred and fear. The teacher assumes about the same emotional attitude toward her principal that she assumed as a child toward her father or her mother. She identifies herself with him or revolts against him. Both attitudes are frequent enough in schools and they do not exclude each other. Teachers identify themselves with their principal in certain respects while they revolt against him in others. Although the attitude of rebellion is by no means infrequent, on the whole, the identifying, complying attitude prevails, not only because this attitude is rationally more advisable, but also because it is much less fraught with conflicts and guilt feelings.

Most teachers are rather unaware how much they are influenced by the views and attitudes of their principal, but for the outside observer this dependency is often clearly recognizable, particularly when the principal is an impressive personality with definite educational views of his own. It is usually the principal who creates what is called the atmosphere of a school. He sets the standards of the school community. His emotional relationship with the teachers greatly influences the emotional attitude of the teachers toward their pupils. The whole school is linked by this bond

of identification. In visiting schools, a visit in the principal's office provides most of the necessary information to a trained observer.

If a psychoanalytically trained expert works in a school and is accepted as a father substitute by some members of the staff, obviously a conflict arises. The principal feels that, somehow, his emotional hold on the staff is threatened. He reacts to this threat of loss of authority and love in about the same way as the teacher to the expert who takes over the treatment of a child. The uneasiness reaches a peak when the principal has to refer a child to the expert, after having tried in vain to cope with the problem. Emotionally, this means that he confesses his own failure and acknowledges the expert as a father authority. Only a very well-balanced person will be able to do that without resentment.

The relationship between principal and expert is certainly extremely delicate, and in order to maintain satisfactory coöperation, tact on both sides is needed. The factual advantage lies with the principal, because it usually depends upon his decision whether the expert may continue to work in his schools. The psychological advantage lies with the analyst, because he understands better the involved emotional character of the situation.

The personality of the principal determines also the more or less formal or progressive character of the school. Though by no means all private schools are progressive and all public schools formal, the larger percentage of progressive schools will still be found among those conducted on private initiative. I am, of course, aware that most schools take some sort of middle course between the extremes, and that all shades are possible, from a progressive to a formal school. When in what follows I mention formal or progressive schools, I mean the extreme types on both sides of this long line, knowing that such pure types do not exist in reality.

The progressive schools should have a particular function in the introduction of psychoanalytical methods. By their very nature, they are supposed to be readier to accept innovations in educational technique than the formal schools. Actually, the psychoanalytic approach is rather advanced in some of them. But the progressive schools have also

special difficulties of their own in accepting psychoanalytic methods.

The difference between the formal and the progressive school is that the former stands for authority, the latter for freedom. In the former, principal and teachers identify themselves with the parents and teachers of their own youth, while in the latter, they identify themselves with the children. In the former, the standards of present-day society are accepted in their entirety, while in the later, these standards themselves are, at least partly, questioned. The former is more exposed to the danger of crushing sensitive children, the latter of spoiling them. In formal schools, children may more easily lose their spontaneity; in progressive schools, their adaptation to the demands of society may be hampered. In the constant struggle between emotion and social standards, the progressive educator is more likely to take the side of the emotion, the conservative one that of the standard. In the formal school, the teacher identifies herself with her superior and with the standards of society; in the progressive school, she identifies herself with the superior, but takes with him a critical stand toward society.

Such contradictory attitudes—identification and submission with regard to the principal, and, at the same time, criticism and rebelliousness with regard to the demands of society—may easily be combined in the same person. They only reënact the two emotional sides of the teacher's own parent-child situation, the loving one and the rebellious one. The love is in such a case reserved for the principal, the hostility for society. The result is a strongly increased emotional attachment to the principal. This attachment and this dependence on the principal will be particularly pronounced when the principal is an impressive and original personality.

It is not only the emotional dependence on the principal, but often a real dependence that is strongly accentuated in private progressive schools, for in many of these schools the principal has the exclusive right of choosing and dismissing his staff. The teachers are, therefore, not only emotionally, but also financially dependent on him. He is not only the wisest, but also the most powerful father figure, resembling much more the primitive childish father image than the average principal of a public school, whose powers

are more limited by board and supervisors. The personality of the principal is important in all schools, but in a private progressive school it is decisive.

When the principal chooses his staff, he follows unconsciously his desire for types who will gratify his emotional wishes, who will worship and obey him, at the same time sharing his ideas and convictions. That presupposes that the teacher's psychological structure is akin to that of the principal. In other words, in choosing his staff the principal finds among the many applicants, always with unerring certainty, the ones who share his own fundamental psychological attitude and his possible neurosis. If the principal is neurotic, he will choose a neurotic staff, and his school will have a particular appeal to neurotic parents and children.

Nothing is surprising in this development except the fact that this connection remains absolutely unconscious to the people in question. They consider themselves normal and a true representation of the outside world, and ward off any suggestion to the contrary. But if by some chance, a really well-balanced person finds his way into such a school, he will leave it rather soon, for he will quite naturally not be able to fit into these surroundings.

What principal and teachers of a progressive school expect from the psychoanalyst, even more than actual help with their problem children, is his confirmation and justification of their educational theories and methods, and that is where he must often disappoint them. The psychoanalyst is by the nature of his work impelled not to go to extremes in any direction. What he is concerned with is the mentally well-balanced personality. He cannot side with those who proclaim absolute authority in schools, for he knows that such an attitude would cripple the emotional life of sensitive children. He cannot propose absolute freedom either, for he is aware that this would endanger the child's social adaptation. His place is between the extremes. His point of view is to give as much instinct gratification to the children as possible, and to impose as many frustration as are indispensable. In terms of authority and freedom, this means giving them as much freedom as they can take and use, and imposing as many rules and regulations as are necessary for a well-ordered social life.

His work is, on principle, possible in both types of school although on the whole a moderately progressive atmosphere, with not too many pedagogical "ideas," will be most favorable for it. The disappointment of the extremely progressive educator is that the psychoanalyst does not share his creed for unconditional freedom, that he does not accept this demand as an objective necessity, but interprets it as an expression of the educator's own childhood experience. People who have been denied freedom in their childhood may well try to make up for it by exaggerated demands for freedom in the education of children. The underlying idea is: "I have been treated badly. These children ought to have a better life."

While in formal schools the psychoanalyst will probably have to defend the emotional claims of the children, in the progressive school his task may sometimes be to reinforce the restrictive claims of society. That renders his task difficult everywhere. The formal school will reject him on account of his revolutionary attitudes, while progressive teachers will suspect him as a reactionary, because he stresses the necessity of guidance in education.

When all these difficulties are considered, it would seem that the psychoanalytic approach to the personal problems of children has no chance of being accepted in schools. If the psychoanalyst is successful in convincing the parents of the usefulness of his activity, he may still fail with the staff or the principal. Actually, the opposition of any of these parties endangers his work, and may easily render it impossible.

But the situation is in reality not quite so hopeless. Parents, teachers, and principals are not only emotional beings who will put up resistance against something of which they are afraid; they also possess reasoning powers and conscience. A person may dislike psychoanalysis very much, but for rational reasons, or out of a feeling of responsibility, still decide to give it a trial. The psychoanalyst in schools will meet not only emotional resistance, but also interest, understanding, appreciation, and coöperation from parents, teachers, and administrators. But it is not the purpose of this article to deal with that side of the question.

BOOK REVIEWS

MATERNAL OVERPROTECTION. By David M. Levy, M.D. New York: Columbia University Press, 1943. 417 p.

The problem of maternal overprotection is one of the weightiest in the work of a child-guidance clinic. Dr. Levy has been interested in this subject for many years and has contributed significantly to its literature. The method used in the present study is unique and original. The cases chosen to bring out salient features of overprotection are reported in detail. They include the observations made by each staff member active in the treatment program during the study at the New York Institute for Child Guidance, where Levy was chief of clinical staff. The reviewer was a member of that staff from 1927 to 1929 and is aware of the care exercised in evaluating steps in treatment. In each of the cases reported in this book, the status of the relationship between mother and child, as affected by the treatment attempted, is described at the time of closing the case and then a year or so later. Follow-up studies when these children had grown up, most of them to adult life, complete the investigation. These later studies were made with the same consideration for details as the earlier studies.

Comments are included in every case presentation and help materially to bring out the causative factors that gave rise to the overprotection and affected the response to treatment. The reader is urged to give special consideration to these case reports. The comments are rich in observation acquired by the author through years of clinical work with children and parents.

Chapter I, *Aims and Methods,* gives a clear description of the procedures used in the investigation. Levy here differentiates between overprotection of the wanted child and overprotection based on compensation for rejection.

In Chapter II, *Case Sifting,* he has subdivided the cases of overprotecting mothers into five categories. The first is the "pure" group. Cases were not included in this group unless there was sufficient contact with the parents to indicate that the data were consistent and that the maternal attitude toward the child was chronic. The so-called "pure" cases of overprotection, according to Levy, "are 'pure' only in their overt clinical manifestations. Whatever the psychic attitudes may be, or, in other words, whatever the mixture of love and hate elements in the maternal attitude, we can say of the 'pure' that it represents one in which maternal

behavior is most clearly and consistently expressed in overprotection."

Later in this chapter, he says, "Before considering other possible neurotic elements in mother-child relationships, it is important to weigh the possibility of a 'pure' overprotection, pure not only in the consistency of the clinical symptoms, but also in the sense of an excess in maternal response not primarily determined by psychotic conflict." Apparently, therefore, he excludes from his "pure" cases a large group seen in clinical practice in which the overprotection is based largely on unconscious guilt.

The extent to which this is a problem in overprotection is reflected in the study made by Miss Freeman, referred to in the chapter *Case Sifting*. Cases of this type, in which the overprotection is mixed with rejection, make up Levy's second group. Even though he does not include these cases in the twenty reported in the present volume, he frequently refers to them and appreciates their importance. He makes many references to unconscious mechanisms. But, as he states, in as much as none of the parents or children reported were analyzed, the author has no knowledge of the part played by unconscious mechanisms. The other subdivisions of Levy's classifications are (3) cases of maternal overprotection in infancy followed later by rejection; (4) cases of mild maternal overprotection; and (5) cases of non-maternal overprotection.

Chapter III deals with the problems of excessive contact. Levy differentiates between the overprotected children who dominated the mother and those whom the mother dominated. It would have been helpful if he had discussed more thoroughly in this chapter the factors that determined the differences between these two groups. References are made later on in the book to the part played by constitution in this.

Levy feels that physical illness early in infancy is an important factor in producing a moderate degree of overprotection, but that it never accounts for the severity in the so-called "pure" cases. Frequently, however, it reinforces the overprotection in these "pure" cases. Excessive contact was an important factor in every one of the "pure" cases.

Chapter IV, *Infantilization*, shows that the overprotected child is kept infantile by the mother much longer than the average child, who is allowed early to do things for himself. The figures quoted are from Miss Freeman's observations. There is a tendency for breast feeding to be prolonged, so that in 49 per cent of the cases, the overprotected children were nursed more than twelve months. This is in contrast to the 32 per cent found among all the children who were referred to the Institute for Child Guidance, and the 20 per cent among rejected children. In going over Miss Freeman's

figures, I felt that it was significant that so many of the mothers who rejected their children nursed them as long as they did. I was also interested in the fact that mothers who overprotected their children through guilt nursed their babies over such a long period. It would have seemed that the deep psychological conflict would have lessened the production of breast milk to a greater extent than it did.

In Chapter V, *Prevention of Social Maturity,* Levy found a tendency for the mothers in the "pure" group to restrict contacts of the child with companions. Apparently this was done in order to have a stronger hold on the child, but it would seem also to imply a punishing element in denying the child pleasure outlets. In general, the number of contacts these children had with companions was related to the social contacts their parents had with other adults. The reviewer wonders whether a mother's difficulty in forming outside contacts might have been a factor in her clinging to the child as a social outlet.

The mothers also showed a marked interest in the child's school work by frequently visiting the school. They coached or tutored the children. Levy repeatedly refers to this as an important factor in the good school adjustments of the children in this group. Indulged as they were in every other way, it might have been expected that the same indulgence would be shown in the matter of school work, but fortunately it was not. There was a definite tendency for the children in this "pure" group to be above the average in reading and language usage. To some extent their achievements were related to the generally higher intelligence of the average child in the group. Their performances in arithmetic were relatively poor. Levy explains the greater ability in reading and language usage as due to increased association with adults and less time spent with children. The mothers were unable to tutor the children in mathematics in the higher grades, because in many instances they had not the ability to do so.

Chapter VI deals with the problems of maternal control. Levy differentiates between two types of overprotection. The first is the overindulgence in which the mother always gives in; she surrenders herself to the child. The result is a prolonged infantilization during which the "infantile behavior is allowed to grow luxuriantly." Children brought up in such an environment are aggressive, difficult to manage, and lacking in respect. There is a tendency for the mothers to refer these children for help. In the other group, the mother dominates the child, but continues to overprotect him as she forces submission from him. Such a

child is obedient and passive, and frequently is referred to as a "sissy." He does not fight back.

Two cases are reported that clearly bring out the differences between the overindulgent and the dominating mothers. The dominating mother rarely refers her child for study; it is usually the agency or school that refers him. Levy does not attempt to explain the factors back of the differences in the behavior of these mothers. He implies that the overindulgent mother may have a deep need to be punished, but advisedly says that there is no proof of this, since the deeper factors are not known through the types of study carried on at the institute.

Levy also refers to the fact that some mothers begin by indulging and then change to the dominating type of behavior after the child has passed through the infantile period.

The seventh chapter, *Maternal and Paternal Factors,* contains a good deal of controversial material, particularly in regard to the factors responsible for the maternal interest of the mother. It begins with the effect upon the increased maternal longing for a child of experiences that threaten the possibility of successful pregnancies. Thirteen of the twenty "pure" cases yielded such data as prolonged periods of sterility, death of offspring, miscarriages, and serious complications of the pregnancy that preceded the birth of the child.

There were sixteen instances of sexual maladjustment in the twenty cases. This is consistent with other studies which have shown that mothers who strongly overprotect their children are poorly adjusted sexually. Levy does not feel that these mothers seize upon the child as a social outlet because of their unsatisfactory sexual life, but because of a deep maternal attachment that is independent of their sexual life.

He also points to the fact that sixteen of the twenty overprotecting mothers in the "pure" group had suffered from severe deprivation of love in their own childhood. He refers to this as "affect hunger," resulting from "the impoverishment in the child of all those positive feelings implicit in parental love—recognition, security, affection, sympathy, and the like. He regards this privation as an important factor in the need of the parents to overprotect their child, assuming that the child is used as a means of satisfying an abnormal craving for love. Here, again, he brings in the theory of strong maternal need in these mothers which intensified the results of "affect hunger," with the resulting overprotection of the child. He differentiates this group from mothers

who have suffered from "affect hunger" who reject their children, because the basic maternal pattern in the mother is weak.

Levy relates the maternal needs or make-up of the mother to a constitutional factor which is affected by the endocrine make-up. He feels that psychological factors play an important rôle in the way a mother will later relate herself to her child, but they are important chiefly in intensifying maternal drives. He implies that these same forces would behave differently in women with strong and with weak maternal components in their make-ups. He cites a good deal of experimental work done on animals to show the existence of the maternal factor and the effect upon it of endocrine changes produced experimentally.

He comes to the conclusion from the studies presented that "the theory of maternal overprotection is based on the operation of certain psychic and cultural forces on women constitutionally maternal to a high degree."

Levy's discussion of Freud's formulations regarding the maternal feelings is not convincing. He disagrees with Freud, largely on the basis of the experimental work done on animals. Freud always took into account the biological features of behavior, and predicted that some of the thinking on subjects related to sex would very likely be changed with new discoveries regarding sexual hormones. The emphasis he placed on the girl's reaction to penis envy and the relationship between this and the future desire to have a child cannot easily be discredited. This is not the place, however, for a long discussion of this controversial subject.

The fathers of the overprotected children in the "pure" group were in general submissive, stable, and good providers. They played minor authoritative rôles in the lives of their children. Twelve of the twenty maintained an affectionate relationship with the child, whereas five showed little or no affection, and three were out of the home. The fathers in their early life, according to Levy, showed a consistent pattern of submissive adaptation.

Chapter VIII deals with the problems of the overprotected. The behavior of the indulged overprotected children was featured by impudence, disobedience, and excessive demands. Levy includes in his discussion of this group the factor of strong aggressive components in the personality. In a high percentage of cases, the need to dominate companions made the indulged child unpopular and shunned. In school, as stated before, the group adjusted surprisingly well because the mothers insisted on acceptable behavior in school. The indulged overprotected children showed a capacity to improve in their relationship to other children at camp and at school, so that Levy feels that if an opportunity had been afforded them

for early social experience with children, they might have learned to make social adaptations.

The dominated overprotected group responded in every instance well in classroom behavior, regardless of I.Q. or of school success. The sexual behavior of this group varied little from that of control groups seen at the Institute for Child Guidance. Feeding problems were numerous, occurring in twelve of the twenty. There was nothing outstanding in sleeping problems. There was no instance of soiling, and only two were enuretic. Levy has formerly postulated the theory that enuresis is closely related to neglect in training, and such neglect would obviously not occur in the overprotected.

In Chapter IX, *Treatment, Prognosis, Psychopathology,* the author feels that the treatment of the children of the overprotected group was uniformly unfavorable. It may well be that more interviews with these children would have produced greater improvement, and Levy recognizes this. It may also be that if the treatment had been limited to trained psychiatrists, the results would have been better. In many instances the treatment was carried on by fellows in psychiatry who had had little work with boys, particularly with boys who were as clever as were many in this group, though the reviewer does not wish to alter the statement that the prognosis of direct treatment of the overprotected child belonging to Levy's "pure" group is bad. Attempts to change the mothers' attitudes failed. Attempts to manipulate the environment by finding other outlets for the mothers were successful for short periods only. The fathers seemed to respond better. Many of them seemed unaware of the extent of their passive rôle, perhaps because it had been going on for such a long time. Many responded with greater interest in the child, which was beneficial. Occasionally improvement was noted with a change of schools or a stay at a camp, or as the result of other outlets.

It is interesting that the follow-up study found so many of these children—all but seven—making relatively good social adjustments, having lost their need to antagonize or to dominate. At least their behavior had been modified sufficiently to attract friends to them. Even several of those who had been dominated were successful in forming friendships despite their shyness.

It is not clear why Levy takes to the use of the term "psychopath" in this discussion. It adds little to clarity. He refers to the deprived psychopath who has been denied affection early and fails to adjust because he has never made a social adjustment and social identification. He refers also to the indulged psychopath who fails to adjust because he is sure of acceptance even if he

makes no effort. He considers this group to be worse off then the deprived psychopath.

In the follow-up group there are four outstanding failures. All belong to the group of indulged overprotected. The dominated overprotected fare better. Only one of the whole group became seriously delinquent.

The detailed discussion in this chapter on evaluations is excellent and should prove most useful in any research planned in the field of human behavior.

The essence of therapy for the child was to find opportunities for him to do things on his own and to encourage him in this. Attempts were made to separate the child from the mother at various times during the day and also for longer periods of time. The mother was encouraged to do things away from home and to spend more time in company with the father rather than with the child. Treatment of the father consisted in helping him to find greater interest in the child. Levy stresses treatment of the father in these situations and rightly calls attention to the fact that this phase of treatment has been neglected. It is interesting that in this study the fathers were the only ones who really seemed to respond to treatment. The author explains this on the basis of the father's having been given a new status—a greater recognition of his rôle as an important member of the family.

The child had no wish to give up his favored status and the mother "refused to surrender her maternal overprotective attitude." Levy's use of the term "refused" in this connection does not sufficiently emphasize her inability to change her attitude, growing out of her early deep ties to the child for many reasons unknown to her and not brought out in the study. Of the nineteen cases in the "pure" group that were followed up, 58 per cent responded successfully or with partial success when evaluated shortly after the close of the studies. The evaluation nine to twelve years later showed that 88 per cent were in the successful group. The factors that were responsible for the early absence of friends had disappeared, for later all but one had friends of their own age and sex, although seven had no close friends. The bullying, show-off behavior, selfishness, and withdrawn behavior had apparently been modified into more acceptable behavior. The twelve cases of dominated overprotection continued as plodding students regardless of their intelligence. With one exception, those who were at work showed similar stability. There were seven cases in this group. Of eleven patients originally classified as aggressive, four showed an early lessening of aggression. Of seven cases whose aggression persisted, three made excellent adjustments and four poor adjustments.

Chapter X contains the case studies of treatment and follow-up. In this discussion Levy attempts to explain the aggression of the child in different situations. Those children who manifested their aggressive behavior in all or most situations were considered as more fundamentally aggressive, in contrast with those whose aggression was limited to the home. Levy considers this behavior compensatory to the mothers' indulgence of children who were fundamentally not aggressive.

In Case 3, the child's aggression was present early in all spheres, but disappeared later. Levy described this child as constitutionally submissive and explained the aggression, which in this case was generalized, as due to the indulgence of the parents, explaining that, later on, life adjustments cut down the aggression. One wonders if it would not be well to include the possibility that this child was fundamentally aggressive, but that later life experiences were of such a nature as to lessen the need to react with hostility and aggression. This is not a major point and the reviewer, too, believes that aggression is a constitutional character. He was impressed in the discussion of these cases with the fact that Levy, who undoubtedly is aware of the significance of environmental factors in calling out aggression, has not given this factor enough recognition.

In discussing the psychoanalytic factors, he says (p. 248):

> "Psychoanalytic investigations reveal the following psychodynamic processes that may enhance maternal behavior in a more or less direct manner: identification of the child with a beloved person; narcissistic gratification in a child of either sex; overvaluation through masculine fulfillment in a male child. Compensatory maternal activities may be derived indirectly through unconscious hostilities towards the child—seen chiefly in maternal apprehension—or unconscious sexual impulses, with resulting unconscious rejection, or overprotection through guilt of rejection."

It is interesting that so many of the overprotected boys made a satisfactory heterosexual adjustment in later life. Levy states that even in those who slept with their mothers over a long period there was no evidence of marked heterosexual conflict. He is aware, however, of the danger of depending upon overt behavior as an indication of a heterosexual adjustment, and of the possibility that more intensive study might have revealed a less successful adjustment than was reported.

It is unfortunate that there was not more discussion of children who were overprotected on the basis of unconscious guilt. Yet perhaps Levy was wise in touching lightly upon this phase of the problem since in too many instances overprotection has been explained on the basis of unconscious rejection that could not be proved. The diagnosis was too often made without giving consideration to the

large number of factors, included in this study, which produce overprotection. As Levy states, the only way one could definitely prove that children were overprotected on the basis of deep rejection would be through psychoanalytic study of the mothers.

We have been very much in need of a complete study of the problem of overprotection, and Levy has given us this in this excellent volume. Every one dealing with the problems of child behavior will want to study it very carefully. Those who wish to do research in any phase of human behavior will do well to use Levy's method as a guide.

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FAMILY SITUATIONS: AN INTRODUCTION TO THE STUDY OF CHILD BEHAVIOR. James H. S. Bossard and Eleanor S. Boll. Philadelphia: The University of Pennsylvania Press, 1943. 265 p.

This book might be called an introduction to the clinical sociology of the family. It attempts with considerable success to bring to the material that is dealt with in child-guidance clinics the point of view and approach of sociology. It consists of two related monographs, the first by the senior author and the second by the junior. Professor Bossard's contribution, found in the first, second, third, and ninth chapters, sets forth, in language easily understood by the mental hygienist, the sociologist's attitude toward family situations and the dynamic interplay of forces in the family with which mental hygienists are familiar, although they look through the eyes of the individual client outward to the family relationships, whereas Professor Bossard looks inward through the family to the individuals that make it up. He also considers, much more extensively than most of us in the mental-hygiene field have yet learned to do, the dynamic interactions between the family and the social forces that play upon it from without. With it all he shows extensive familiarity with the writings and thinking of people in the mental-hygiene field, and constantly relates the sociological point of view to that of the older clinical approaches.

The second half of the book is a preliminary attempt to develop what might be called a system of family sociology similar to a system of medicine. It consists essentially of generalized clinical descriptions of different sorts of family viewed as organic wholes. For the most part these are very well done. Mrs. Boll has a real flair for general description, and over and over again the mental hygienist comes across descriptions into which he can fit families that he has dealt with clinically.

In the opinion of the reviewer, however, this part of the book was marred by the attempt to be oversystematic. The clinical descriptions are preceded by a classification in table form of family situations which is developed *a priori* from generalized sociological conceptions. This results in two faults. The less serious is that the author has felt under an obligation to fill in all the blank spaces provided in the outline, with the result that there is considerable unevenness in the quality of the clinical pictures. The more serious criticism is that at this stage in the development of clinical sociology the attempt to develop an all-inclusive, and a mutually exclusive, system of family situations is apt to result in too early crystallization of our thinking, particularly in regard to etiology. There are etiological implications behind the system as presented, and there is danger that the use of a closed system like this will close the mind of the investigator to the discovery of unknown etiology.

The whole thing is a little too reminiscent of humoral medicine. This was a beautifully logical system of classification, and some of the humoralists were brilliant in their clinical descriptions when they could forget their systematic preconceptions, but the system was sterile. It is too bad that Mrs. Boll was not more familiar with good modern systems of medicine, for she would then have discovered that, in spite of two and a half millenia of clinical practice, a practically useful system of medicine has not yet been developed that is water-tight logically. Many of the same diseases have to be described in two different places—first, under an etiological classification and, second, under a systemic one.

The first step, however, toward developing a clinically useful, as contrasted to an æsthetically satisfying, system of family situations is the development of good general clinical descriptions, and Mrs. Boll has made a very significant first step here. It is to be devoutly hoped that it will stimulate others to develop similar generalized pictures from their clinical experiences.

All in all, the book is one that can be read with profit by all workers in the mental-hygiene field, as it should help us to organize our thinking about the fact—which we can no longer ignore—that just as the child cannot be understood unless we see him in relationship to the lines of force within the family, so the family cannot be understood unless we understand the similar forces that play in both directions between it and the larger society.

Another not insignificant point in the book's favor is that it is concise and at the same time very readable.

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MARRIAGE AND THE FAMILY. Edited by Howard Becker and Reuben Hill. Boston: D. C. Heath and Company, 1942. 663 p.

This book, intended for the college course on marriage and the family, symbolizes the changes that have occurred in that course in recent years. The early books on the family were historical and ethnological, emphasizing the institutional aspects. Later came an interest in practical materials that would help young people prepare for marriage. Now we witness the tendency to combine the two approaches in a single course, and there is much to recommend the combination. The inclusion of practical topics vitalizes the course, while the retention of the traditional materials gives the necessary background.

Part I of *Marriage and the Family* furnishes some of the traditional background material regarding the cultural context of the family. Separate chapters treat of the underlying biological factors, preliterate patterns of family life, the family in Western civilization, and contemporary family types. In this last chapter, there is some interesting new material on family life in Latin America and in India.

Readers of MENTAL HYGIENE will be interested principally in Part II—*Preparation for Marriage;* Part III—*Physical Factors;* Part IV—*Marriage Interaction and Family Administration;* and Part V—*Problems of Parenthood.*

Under the first of these headings, there is a chapter on personality development and marriage which describes the development of personality and suggests how personality patterns built up in childhood influence subsequent adjustments in marriage. Stress is placed on the importance of "habits of happiness" and on emotional balance. Chapter 8, *Love and Courtship,* answers questions regarding the nature of love and its importance for marriage. Chapter 9, *Assortative Mating,* discusses factors governing actual choice, with emphasis on the limited social world from which selection is generally made. Chapter 10, *The Engagement,* with discussions of the problems and opportunities of this period, concludes Part II.

Part III has useful chapters on heredity, on sex intercourse, and on prenatal care and childbirth, in which specific information is detailed. Part IV includes chapters on the first year of marriage, factors in marital adjustment, marriage conflict, marriage and money, techniques of family administration, and family shelter. Part V treats of parent-child interaction and family life and religion.

I mention these chapters specifically in order to give some idea of the comprehensiveness of the book. But there is even more. Part VI deals with family crises and ways of meeting them, and the nature and extent of divorce; and the final section, Part VII, covers the

war and the family, the family and the declining birth rate, and the future of the family.

In a volume so diversified, involving twenty-seven authors, it is not surprising that there are some things to be criticized. Although the book is on the whole scientific and close to the facts, here and there the reader is offered old-time advice of questionable value. The difficulty arises from the fact that some writers on marriage feel they must answer all the questions, despite the fact that all the answers are not yet available. Much traditional advice that sounds like good common sense has lately been discredited, or at least questioned, by scientific research.

For instance, one of the most urgent warnings given to newly-weds is that against having too much to do with their in-laws and relatives. It is thought that frequent visits from in-laws are bad enough, but that living with them is worse. Why this belief should be so general is not clear, but it seems to be consistent with the present economic organization of the American family in independent households. In view of the widespread in-law bugaboo, the negative findings of research are particularly interesting. They show that there is no significant difference in marital happiness between those who live with relatives or in-laws and those who do not.[1] Similar criticisms can be made of other "common-sense" precepts.

These criticisms are counsels of perfection. Taken as a whole, the book is remarkably sound. Indeed, if you stack it up against others that attempt to meet the same need, the reviewer believes you will find none better.

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STUDIES IN PERSONALITY, CONTRIBUTED IN HONOR OF LEWIS M. TERMAN. Edited by Quinn McNemar and Maud A. Merrill. New York: McGraw-Hill Book Company, 1942. 333 pp.

Memorial volumes are usually rather stuffy reading, with possibly one or two outstanding articles lost among a score of mediocre ones. The present volume is an exception to this rule. This reviewer cannot recall a more interesting, stimulating, and thought-provoking collection of psychological studies. Eight of the contributions—those by Burks, Fearing, Klüver, Miles, Sears, Shen, Tinker, and Young—are of such outstanding merit that one or more, according to field of interest, should be on the must-read list of all psychologists.

The introductory chapter by Robert S. Woodworth traces Terman's persistent and continuing interest in the origins of individual differ-

[1] See *Predicting Success or Failure in Marriage*, by Ernest W. Burgess and Leonard S. Cottrell. New York: Prentice-Hall, 1939. p. 413.

ences, of stupidity and genius. Roger G. Barker reports a nicely controlled study of the resolution of conflict by children in situations involving preferences for seven liquids, ranging from pineapple juice to vinegar.

Barbara S. Burks describes a pair of monozygotic twin girls reared apart from the age of nine days in rather dissimilar environments. The twins were studied intensively at age twelve and again at eighteen. Franklin Fearing presents an illuminating discussion of the interview situation and an instructive analysis of the ratings made by four interviewers on one hundred police officers who were candidates under civil service for promotion to the rank of captain of police.

Florence L. Goodenough illustrates, in the measurement of masculinity-femininity, a novel method of scoring free-association responses in which homonyms are used as stimulus words. H. F. Harlow contributes a study demonstrating the ability of rhesus monkeys to respond to highly complex learning situations. L. P. Herrington reports a correlation between physiological and social indices of activity level. E. Lowell Kelly examines data from three hundred engaged couples, failing to find any positive relation between source or adequacy of early sex information and later personality ratings.

John L. Kennedy draws some rather doubtful conclusions from questionnaire data as to the degree to which the beliefs of college students in supernormal phenomena have changed during the last twenty-five years. Heinrick Klüver evaluates and organizes a wide range of technical evidence on the origins of hallucinatory phenomena.

Catharine Cox Miles reports a study of a young adult male pseudohermaphrodite reared as a female until twenty years of age. The embarrassment of a beard finally led to surgical exploration of the abdominal organs. Testicular, but no ovarian, tissue was found. Two weeks after he was surgically treated and told his true gonadal status, he scored above the eightieth percentile in psychological masculinity.

Floyd L. Ruch describes a technique for detecting attempts to fake scores on self-inventory types of personality tests. Robert R. Sears discusses the influence of feelings of success and failure in learning situations and presents a brilliantly conceived and executed experimental demonstration of the interplay of forces which have so often, in less well-designed experiments, yielded only confusing results. Eugene Shen presents a series of six tests of the statistical significance of experimental findings which permit a far more searching analysis than is commonly employed.

Miles Tinker contributes a study of the speed of saccadic eye movements, analyzing the influence of the angle through which the

eye moves and of individual and sex differences. Willoughby summarizes a report, elsewhere published in full, of the characteristics of two contrasted groups of families receiving help from social agencies. Kimball Young examines and quotes at length from letters and diaries illustrating the impact of polygynous marriage on the personality of wives and husbands in Morman families.

The high order and wide range of these contributions are fitting tributes to the genius of Professor Terman.

FRANK K. SHUTTLEWORTH.
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THE ETIOLOGY OF DELINQUENT AND CRIMINAL BEHAVIOR: A PLANNING REPORT FOR RESEARCH, By Walter C. Reckless. (Bulletin No. 50 of the Social Science Research Council.) New York: Social Science Research Council, 1943. 169 p.

Professor Reckless recognizes three phases in the development of research into the etiology of criminal behavior. The first period, the classical era of criminology, brought forth various particularistic theories, explaining crime and criminals. These theories were often in opposition to one another and usually were based on speculation and inadequate data. Healy, with his study of individual case histories and the affirmation of multiple causation in individual cases—in contrast to single causation for crime and criminals in general—wrote finis to this first phase.

The second period was characterized by a drive for first-hand data. In driving straight for the facts, the studies became segmented and disjoined, following many diverse paths in the attempt to discover the relationship of this or that factor to crime and delinquency. Reckless devotes a great part of his report to the enumeration and analysis of the various efforts to find the causes of criminal behavior in the constitution of man or in the situations confronting man. The various claims of the constitutionalists are based on the factors of heredity, subnormal intelligence, mental abnormality, endocrine determination, body build and physical type, and the psychodynamics of behavior. The investigations of the situationalists stress the factors of family situations (broken home, sibling position, unsatisfactory relationship within the family, presence of demoralized persons in the home), companionship (lone-wolf offender or accomplices in crime), community disorganization, gradient tendency in the spatial distribution of crime, urban-rural differences, regional differences, agencies of moral risk (existence of saloons, gambling parlors, cheap dance halls, and so on in a given neighborhood), agencies of mass impression (newspapers, magazines, movies, and radio), migration, business cycles, *et al.*

Reckless takes issue with the constitutionalists for their failure to incorporate in their studies the operation of situational factors, and vice versa with the situationalists. He blames the constitutionalists in particular for not having proven what factors operate in persons who display criminal behavior, but not in persons not displaying such behavior; for instance, "we do not know which psychopaths do or do not become criminal." Reckless credits the situationalists with having tried in some instances, "but not thoroughly enough," to prove that certain items apply more often to offenders than to non-offenders. He criticizes some situationalists, however, for confusing causative factors with risks—for instance, in the studies of the volume of crime as related to community disorganization, economic depression, and migration (from simple and backward to a more complex and advanced environment). And it is *causation* of crime and delinquency that Reckless wants to see investigated.

The present, third period of etiological research in criminology is devoted to the systematization of previous studies; Reckless calls it the period of reformulation. As efforts toward systematization, he mentions first the school of criminal biology (as represented by Viernstein, Lenz, Raumer in Europe; Healy, Bronner, and the Gluecks in America) which, however, is "more interested in typology than in establishing causal relationships." He mentions, further, Sutherland's and Sellin's formulations. Sutherland contends that "the chance that a person will participate in systematic criminal behavior is determined roughly by the frequency and consistency of his contacts with patterns of criminal behavior," and that "cultural conflict is the underlying cause of differential association" (*i.e.*, association with persons who commit crimes). Sellin suggests study of the violation of conduct norms which are the rules that "prohibit and conversely enjoin specific types of persons, as defined by their status in the normative group, from acting in a certain specified way in certain circumstances." The ultimate aim of etiological research, according to Sellin, should be the ability to state that if a certain type of person is placed in a certain type of life situation, he will probably react in a certain manner. Its enormous practical value in the field of crime prevention in general, and of probation and parole prediction in particular, is obvious.

In the final chapter of his monograph, Reckless underscores the fact that "the biggest scientific handicap heretofore in the study of criminal and delinquent behavior or of criminals and delinquents has been the lack of knowledge about conforming and nonconforming behavior and of conformists and nonconformists to the various rules of conduct." In order to get the largest possible control group,

he suggests a large-scale, long-time study embracing all available methods—viz., collection of case studies and life histories, sociometric, psychometric, and psychophysical tests, and multiple factor analyses.

Such a sample study, so he envisions, would reach "every white boy enrolled in the fifth grade of the schools of a medium-sized large city," and would secure fingerprints, background facts, physical examination, mental tests, school reports, social-agency clearance reports on the family, juvenile-court files, responses on two or three sociometric or psychometric inventories, and ratings in terms of nonconforming conduct from teacher, mother, and closest friend. Provision would be made for follow-up studies, year after year, for a period of ten years.

Besides this gigantic study, Reckless suggests a number of studies on a smaller scale, filling important gaps in knowledge. Among others, he mentions Hans von Hentig's suggestion regarding a study of the relationship between climatic conditions and criminality. (It is significant in this connection, the reviewer feels, that the recent outbreaks of mob violence in Detroit and Harlem occurred on extremely hot days.)

Reckless further recommends as practical steps the establishment of an Academy for Research in Delinquent and Criminal Behavior comprised of persons actively engaged in criminological research from the several contributing scientific disciplines; the provision of sizable funds, both governmental and private, for criminological research (which, in comparison with other active fields, so far has had very meager support); and improvement in the uniformity of crime reports and greater standardization and accuracy of recording personal data on offenders. In order to serve teaching as well as research purposes, files of recorded case studies that meet the requirements of several converging disciplines should be developed.

Reckless finally proposes the use of adult and juvenile courts, police departments, parole and probation agencies, and correctional institutions as research laboratories, and advocates a coöperative relationship between universities and correctional agencies and institutions.[1]

In the appendix to the monograph, research resources and opportunities, records and statistics on crime and criminals, and special problems and projects in the field of criminological research are discussed by a number of practitioners and theorists.

As Professsor E. W. Burgess, Chairman of the Committee on

[1] Similar suggestions were made by the reviewer in an article, "Developing Community Understanding of Probation and Parole Work," in the *Journal of Criminal Law and Criminology*, Vol. 33, pp. 23–31, May–June, 1942.

Problems and Policy of the Social Science Research Council, points out in his foreword, the monograph is an "attempt to promote unified effort by the different disciplines—psychiatry, psychology, and sociology—engaged in the study of the causes of delinquent and criminal behavior." The monograph is exacting in its scientific demands and realistic in its practical recommendations.

JOHN OTTO REINEMANN.

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NERVOUSNESS, INDIGESTION, AND PAIN. By Walter C. Alvarez, M.D. New York: Paul B. Hoeber, Medical Book Department of Harper and Brothers, 1943. 488 p.

As the title suggests, the scope of the material included in this book is vast, though it stays fairly well within the area of the complaints that come most frequently to the gastroenterologist. The audience is not specified, but despite the book's chatty style, there is enough technical material throughout, as well as specific suggestions for therapy, to warrant the assumption that the author is writing for the medical profession. Occasionally, however, a wider audience is implied, when he presents his material directly to the theoretical patient.

The book is written in a simple, easy style and includes everything from pertinent autobiographic episodes to diet lists. It concerns itself with the differential diagnosis between organic and functional disease, and is drawn from the experience of a wise clinician who has had many years' experience in sizing up people. One of the chief drawbacks of the book is its tendency to be repetitious. Frequently, however, one finds nice bits of humor or philosophical whimsey or human-interest stories that keep it from being dull reading.

The heart of Dr. Alvarez' message is given on the title page, where he quotes Maudsley thus: "The sorrow which has no vent in tears may make other organs weep"; and again on page 357, where he says that "abdominal distress is a common initial symptom of psychoneuroses, psychoses, and other diseases of the brain. In the future more effort must be made to recognize these syndromes before unnecessary and futile abdominal operations are performed." If the book assists in the achievement of this goal, it will have made a real contribution.

From the point of view of a psychiatrist, the book leaves much to be desired. Despite the author's emphasis on the emotional factors in illness, there is no evidence of insight into the awareness of *unconscious* motivations of illness or of the fact that psycho-

therapy is much besides a kindly, but firm pep talk, or that symptoms referable to the gastrointestinal tract may have any sensible significance. One is, therefore, not surprised when names such as Alexander or his associates at Chicago are not listed in the rather extensive bibliography. There is an extremely liberal use of heredity as the scapegoat for almost all types of behavior that are nonconformist, and the terms "insanity" and "psychopathic" are used without stint.

Possibly the greatest disappointment in the book is the fact that nowhere does the author suggest that trained psychiatrists might be helpful to any of his patients. Nowhere does his voice of authority help a patient to accept the need for psychiatric treatment or to make plans for obtaining it. Nor does he suggest that other physicians for whom he is writing might render invaluable aid to patients through preparing them for psychotherapy or psychoanalysis. It would indeed have been a pleasant experience if so worthy a representative of the great Mayo Foundation had pointed the way to his younger colleagues to being as helpful as possible to "nervous" patients, since, as he says, such a large percentage of the patients seen fall into this category.

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UNIT MEDICAL RECORDS IN HOSPITAL AND CLINIC. By Dorothy L. Kurtz. New York: Columbia University Press, 1943. 110 p.

This small volume constitutes an excellent guide for the preparation, systematic arrangement, and filing of records of patients in general hospitals. The system of records described is that used by the Presbyterian Hospital, which forms a part of the Columbia-Presbyterian Medical Center.

In the history of medical records given in brief in the first chapter of the book, the author pays tribute to Hippocrates, who was probably the first physician to use case records of his patients. From Hippocrates down to the present time, some sort of record has accompanied the scientific treatment of patients, but it was not until 1916 that the Presbyterian Hospital began the operation of its unit record system. Many other hospitals have recognized the value of the unit system and it is probably in use, in part at least, in most of the larger general hospitals of the country.

In the second chapter of the book, the author gives a detailed description of the contents and arrangement of the unit record. It begins with the front unit or index sheet and is followed immediately by the chronological record, which proceeds from the first contact

with the patient to the last through both clinic and hospital care. The author sets forth the following order of items in the record:

> *Application data.*
>
> *Initial examination,* including complaint, family history, personal history, present illness, physical examination, and provisional diagnosis.
>
> *Progress notes,* comprising the running record of observations, conclusions, and recommendations of the doctor attending the patient.
>
> *Special examination and treatment records,* including laboratory reports, special examinations and treatments, correspondence, and finally autopsy reports, which, naturally, appear only when the patient dies in the hospital.

It will be seen that the unit medical record described by the author is very similar to the case record used in the better mental hospitals.

For the maintenance of the unit record, a number system is required as an aid to indexing and reference. Each patient on admission is assigned an identification number and all records concerning the patient should bear this number. If a patient should return to the hospital after being discharged, he would continue to have the original number and the records of his second treatment would become a part of his unit medical record.

The author discusses the indexing of records and explains the method of constructing an index upon the Standard Classified Nomenclature of Disease.

In the final chapter the use of the records for research is described, and the author points out various ways in which the important items in the record may be tabulated.

The book as a whole fulfills its purpose most admirably. It should prove of great assistance to record clerks and librarians in all kinds of large hospital.

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IN SEARCH OF MATURITY. By Fritz Kunkel, M.D. New York: Charles Scribner's Sons, 1940. 292 p.

This is the seventh of Kunkel's volumes—all more or less expounding his view of the We-psychology. As he has earlier pointed to the necessity of an integration of the conscious with the unconscious, and of the individual with his intimate family and neighbor group, the present book points to this integration at the level of the individual and God's will—the ultimate values.

Part I is concerned with the regrettable schism between religion and psychology. It recalls the author's earlier exposition of the We-

psychology and the tensions that develop from our culture's forcing each of us to build an Ego-psychology (egocentricity). The main question to which the rest of the book addresses itself is that of "how we can do His (God's) will if we are controlled by these super-individual powers."

In answering this, Part II discusses the channelizing of the powers of the collective unconscious into an ego structure that is conditioned by a striving, selfish world. The resulting distortions are our rebellion against God's will—against what He would wish His world to be. In our distress we often turn to others quite as egocentric as we are, giving ourselves in blind loyalty to them and their causes, instead of to His still, small voice. This is idolatry—and as an analysis of the power and effectiveness of leadership, this chapter is thoroughly worth careful reading.

It is not until the beginning of Part III that Kunkel makes it clear that he considers the tendency of evolution (as summed up in the collective unconscious) and the will of God as synonymous. Each author has a right to his definitions, but when a book frankly starts out to bring together religion and psychology, when for two hundred pages it carefully capitalizes the Deity and gives the impression of His personal integrity, when it buttresses many of its pages with quotations from the Scriptures, a great many readers are going to come to this definition with a feeling that the author has scarcely been fair with them.

Part III deals with self-education. It points out to the individual how he can come more into tune with God's will (that is, with his own unconscious). This is chiefly through meditation. This plea for self-analysis—for a tolerant acceptance of what the deeper layers of our unconscious are trying to tell us—would be more convincing were it not that the mess that most of us are in is due precisely to our inability to make this analysis. Kunkel would have us "write out and meditate on a list of all our black and white giants, with all their good and bad qualities, as we see them." Excellent advice—but the only ones who can effectively follow it don't need it.

Kunkel has written other and, to the reviewer's mind, much better books (as, for instance, *Character, Growth, and Education*). His conception of the problem of tension as one that can be stated in terms of the distortions developed as the ego differentiates itself from the collective unconscious, is magnificent. Perhaps no other worker has stressed so properly the therapeutic problem as one of synthesis rather than of analysis. At every point in Kunkel's work integration of the total personality stands as the one goal. Obviously this calls for a friendliness between the conscious and the unconscious—between the mental and the deepest and most archaic of the physical. (Here at

one fell swoop is the whole business that we in the area of psychosomatic medicine have been busily nibbling away at!)

This building of a whole out of opposites Kunkel carries to many other areas than that of the physical and mental. He has done this particularly well in the present volume—showing that as long as we consider aspects as opposites rather than as but two sides of a whole, we fail to see the "union of opposites" which is one of the fundamental laws of integration. He is a bit hypnotized by two—a whole may have three or six or eight "sides." But the reader will find here a clean-cut resolution of the problem of opposites as they are seen as but aspects—different sides—of the whole.

"The transformation of the collective powers from the original We-structure into the structure of the maturing We-experience . . . is spiritual growth." This Kunkel has told us brilliantly before. The present volume is a re-affirmation and, to some extent, an elucidation of this proposition. One does not need to be a theologian to claim that it would have been more forthright to put this statement on the first instead of on the last page. In these days of keen and beautifully verbalized analyses, Kunkel's reiterated thesis that the essential problem is that of the freeing and strengthening of the motifs that run through the symphony of life calls with a new and fresh vigor.

This emphasis on integration is practical and useful. As Hayakawa puts it, "Philosophy through the centuries has been hung up on the dilemma of attributing the 'spiritual' aspect of man to *super*natural origin, thereby relinquishing all claim to being able to affect it by other than magical means." Kunkel has done a great service in pointing the way to a union of these two "opposites"—the natural and the supernatural. But, I reiterate, so fundamental a challenge to the ordinary assumptions of the ordinary person would have been more fairly stated as an introduction rather than as a conclusion. It is too bad that the present volume gives the impression that the author is using a trick of words to bring to his support many who would have come just as loyally had he from the start used only "psychological definitions." No one would be more upset than Kunkel over the theologian who insisted on giving religious meanings to psychological terms. It equally spoils a good book to give only psychological meanings to religious terms.

I don't like this dichotomy, but *In Search of Maturity,* with all its clear discussion of the resolution of opposites, forces it.

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TALL MEN HAVE THEIR PROBLEMS, TOO. By Francis Behn Riggs, with an introduction by E. A. Hooton. Cambridge, Massachusetts: Privately published, 1943. 147 p.

Although dedicated to the towering fellow citizens of the author, who himself looks down from a rather lonesome height of six feet, seven inches, this unpretentious monograph is more than a popular guide for excessively tall men. Its stated purpose is to give encouragement and practical help to big fellows who are inclined to consider tallness something of a handicap. In addition, it constitutes a source of interesting information about the physical and psychological aspects of overgrowth.

The classification "tall" is reserved in this survey for men of six feet, five inches and over, since males ranging from six feet, three inches to six feet, four and three-fourths inches are seldom found to be really height-conscious. "Giants" are defined as men whose stature is seven feet or over. According to this definition, there are very few true giants in the world, and the reported heights of most of them are said to be exaggerated. The author's estimate is that the heights of the thirteen tallest giants of the world varied from seven feet, nine inches to eight feet, eleven inches. It is to be expected, of course, that practically all of the real giants are acromegalic and seriously handicapped, which is not true for a majority of tall men.

The author's biological analysis of tallness is based on a study of 231 tall men. Their mean stature was six feet, six and one-fourth inches, while their range extended from six feet, five inches to seven feet, two and one-half inches. The mean stature of their fathers was six feet, three-fourths inch, and that of the mothers five feet, seven and three-fourths inches. The main support for a genetic theory of excessive growth was obtained from genealogical investigations, which indicated that genetically determined oversecretion of the pituitary gland may be due either to the doubling of dominant genes that produce tallness or to an inherited deficiency involving lack of growth inhibitors. Sufficient emphasis is placed by the author on the statement that the effects of genetic and environmental factors responsible for the development of normal and abnormal stature are considered interdependent.

Increase in stature is shown to have been a universal modern phenomenon, which seems closely related to the advancement of civilization and does not affect the general tendency to longevity. The present number of American men of six feet, five inches and over is probably in excess of 10,000, and this number may be trebled in a generation. It is fortunate, however, that any individual disadvantages that may be the result of this racial development will be amply compensated for by greater slenderness, relative muscular and osseous

superiority, and more advantageous specific dimensions, such as relatively shorter feet.

The psychological handicaps of tall men are described as the result of oversensitiveness because of their conspicuousness, of constant exposure to the jealous reactions of short employers and co-workers, and of the common misconception that tall men are clumsy and dull. Other difficulties are caused by the inability to wear ready-made clothing and to enjoy the use of standard-sized beds, chairs, and public transportation facilities.

The author's advice to maladjusted tall men is straight and well-formulated. It is expressed in simple sentences such as the following: "Perhaps the best solution of the tall man's trouble lies in an understanding wife—the size is unimportant—and children who are better than he."

The reviewer's initial statement that this monograph is unpretentious refers neither to its title nor to the brief introduction by Hooton. Certain unqualified claims in the introduction—such as, "To me, bumptiousness, aggression, and conceit seem to vary in individuals inversely with stature"—are evidently exaggerated generalizations which may prejudice many readers. The reviewer was among them, although according to his own anthropometric measurements he should have been flattered.

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THE EDUCATION OF NURSES: HISTORICAL FOUNDATIONS AND MODERN TRENDS. By Isabel Maitland Stewart. New York: The Macmillan Company, 1943. 399 p.

The Macmillan Nursing Education Monographs are intended for the use of professional students and nursing educators. The author of the present volume, an accomplished director and teacher of nursing, has presented a history of nursing from primitive times to the present with most of the emphasis on what has happened from 1860 on, particularly in this country. All this is the background of her argument for what she considers the proper position of nursing in the scheme of society, the proper theories of training, the way to develop leaders in nursing education, and what they should do when developed.

In primitive times the weak, young, old, and ill were cared for by those members of the family or tribe who stayed at home. Some of these were elderly or feeble; they may have been men, but some at least were women. Younger members of the family learned by watching their elders; occasionally they assisted in some detail. In ancient

Greece there seems to have been no division between the medical student and the nursing student, and indeed a century ago in this country patients received from physicians many services that are now performed by the nurse. Patrician women undertook the care of the sick and needy in the Christian era. The crusading knights developed hospitals for the care of their sick and wounded. Military standards provided the pattern for their administration. Education was by precept and practice in routines. Secular nurses of the servant group were uninstructed.

When Miss Nightingale's movement got under way, it met and overcame a great variety of objections. The author seems to regret the submergence of schools of nursing into hospital organizations, which fiscal causes brought about. Service to patients being thus put into competition with nursing education rather than into its support, the lack of sound educators in this field became obtrusive. As alliances were formed with colleges, the better-educated girls turned toward the schools that grant degrees.

Inevitably Miss Stewart aligns herself with those who advocate increase of the preliminary schooling, the longer academic course, and the teaching career of nurses. She restrains her impatience with those whose need of good nursing is not coupled with ample funds to hire plenty of graduates. If she is right in believing that progress in nursing has come from within, we are bound to stand aside when that progress sweeps over the academic field, leaving hospital administrations a little forlorn in their struggle to get what their patients need. But that is the job of the hospital administrator, not of the nursing educator, and he must raise the money or improvise accessory personnel.

Miss Stewart raises many questions that are difficult to answer. She does not offer a quick, infallible method of developing nursing leaders, but she does make interesting suggestions.

The book is arranged for use in teaching; every chapter is summarized and supplemented by questions for discussion. Probably anything more than its casual mention of mental disease would have been outside its scope. The volume will have profit and interest for all those who care for patients in hospitals or at home, for hospital trustees, and for teachers in other educational fields. Many who look for general information also will find it interesting and easy to read.

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MARY E. CORCORAN.

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NOTES AND COMMENTS

Compiled by

MARY VANUXEM, PH.D.

New York State Committee on Mental Hygiene of the State Charities Aid Association

ANNUAL MEETING OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

The Thirty-fifth Annual Meeting of The National Committee for Mental Hygiene will be held at the Hotel Pennsylvania, New York City, on Thursday, November 9. In connection with the meeting there will be a two-day conference of papers and discussions, beginning Wednesday, November 8. The program will be as follows:

Wednesday, 9:30 A.M. to 12 noon, session on "The Mental Hygiene of Industry and Reconversion"; 12:30 to 2:00 P.M., luncheon meeting for executives, board members, and friends of mental-hygiene societies, with a talk on "Needs and Opportunities in the Mental Hospital Field"; 2:00 to 5:00 P.M., session on "Rehabilitation and the Returning Veterans."

Thursday, 9:00 A.M. to 12:00 noon, session on "Race Relations"; 12:30 to 2:30 P.M. annual luncheon and meeting of The National Committee for Mental Hygiene, with reports by the medical director and the treasurer, followed by a program of papers on "Mental Hygiene Considerations in Peace Plans"; 2:30 to 5:00 P.M., session on "Services to the Mentally Ill To-Day."

There will be a registration fee of $1.00, which will cover admission to all the scientific sessions. A charge of $2.25 will be made for each luncheon meeting.

A $10,000 GRANT FROM COMMONWEALTH FUND FOR FELLOWSHIPS IN CHILD PSYCHIATRY

A grant of $10,000, from the Commonwealth Fund of New York to The National Committee for Mental Hygiene, for fellowships to train psychiatrists in work with children, has been announced by Dr. George S. Stevenson, Medical Director of the National Committee.

The fellowships will provide basic training in child psychiatry for some of the recipients, advanced training for others who already

are leaders in the field, and refresher courses for men returning from the armed services.

Dr. Stevenson pointed out that the sharp increase in child delinquency brought about by war conditions emphasizes the importance of training as many child psychiatrists now as possible.

The recipients of the fellowships must have studied psychiatry for two years.

Psychiatric Rehabilitation

The following material is quoted from a recent bulletin of the Division of Rehabilitation of The National Committee for Mental Hygiene:

> "At present the rehabilitation of returning servicemen and women in this country involves three major concerns, in each of which there is considerable development.
>
> "*Referral Centers.*—States and cities are concerned to coördinate their resources and bring information regarding these resources to the men who are being discharged. Informational leaflets are being developed in many communities, and larger cities especially are experimenting with veterans' service centers. The War Manpower Commission has established centers in New Haven, Connecticut; Philadelphia, Pennsylvania; Minneapolis, Minnesota; Houston, Texas; and Denver, Colorado. A number of other cities—Boston, New York, Cleveland, Charlotte, N. C., and others—have set up centers and are proceeding on a somewhat experimental basis. The organizational set-up differs from place to place, and the results appear to differ widely also. It will be very worth while to study these centers to evaluate their effectiveness, as dependent upon variations in organizational set-up and methods of operation. It appears at this moment that larger numbers of men use the centers and are better pleased with the services where thoroughly qualified and experienced professional interviewers are used to explore with the veterans their problems and insure a correct referral in the first instance for the particular help wanted.
>
> "*Rehabilitation Clinics.*—Because of the high incidence of discharges for psychiatric reasons and the relative dearth of professional personnel still in our civilian communities, special efforts are being made to establish clinics for psychiatric rehabilitation.
>
> "In the following communities clinics as listed are already operating: *Boston:* Psychiatry Clinic of the Psychoanalytic Institute, 82 Marlboro St., Dr. Felix Deutsch, Director; Salem Veterans Clinic, Salem Hospital, Essex County, Dr. Clarence A. Bonner, Director (Auspices, State Dept. of Mental Health); Southard Clinic, 76 Fenwood Rd., Dr. Harry C. Solomon, Director (Auspices, State Dept. of Mental Health). *New York:* New York Hospital Rehabilitation Clinic, 525 E. 68th St., Dr. Thomas A. C. Rennie, Director; Lennox Hill Hospital Rehabilitation Clinic, 76th St. & Park Ave., Dr. J. H. W. van Ophuijsen, Director; Red Cross Rehabilitation Clinic, 401 Fifth Ave., Dr. Nathan W. Ackerman, Director; Jewish Hospital Rehabilitation Clinic, 555 Prospect Pl., Brooklyn, N. Y.; Lebanon Hospital Rehabilitation Clinic,

Westchester and Caldwell Aves., Dr. Wm. Silverberg, Director; Beth Israel Hospital, Stuyvesant Park E. & 17th St., Dr. Louis Wender, Director; Mt. Sinai Hospital, 5th Ave. & 100th St., Dr. David Ross, Director. *Kentucky:* Louisville Mental Hygiene Clinic, 610 S. Floyd St., Louisville 2, Ky., Dr. Carl Whitaker, Director. *Missouri:* McMillan Hospital Psychiatric Clinic, 3720 Washington Blvd., St. Louis, Mo., Dr. Sydney B. Maughs, Clinic Director. *New Jersey:* Northern New Jersey Mental Hygiene Clinic, Greystone Park, N. J., Dr. Earl W. Fuller, Director. *N. Carolina:* Mental Hygiene Society Clinic, 121 E. Third St., Charlotte, N. C., Dr. R. Burke Suitt, Director. *Rhode Island:* Providence Child Guidance Clinic, 100 North Main St., Providence, R. I., Dr. Temple Burling, Director.

"The following cities are in the process of establishing rehabilitation clinics: Richmond, Virginia; Kansas City, Missouri; Denver, Colorado; San Francisco, California; and Chicago, Illinois (at least two).

"In Westchester County, N. Y., there is an interesting development which can, perhaps, be duplicated in other suburban communities. Special provision for psychiatric rehabilitation has been made by the Subcommittee on Mental Health of the Committee on Public Health of the County Medical Society. The nine psychiatrists willing to give some time in rehabilitation work are listed with the social agencies, Selective Service boards, and others who might be in a position to refer veterans. Since the physicians live in various communities throughout the county, it makes service more readily accessible. The physicians make their own arrangements with the veterans as to fees or free service, depending upon the resources of the patient and his willingness to pay.

"This division [the Division of Rehabilitation of The National Committee for Mental Hygiene] is now in the process of canvassing all known psychiatric and mental-hygiene clinics in the country and compiling a list of those willing to accept referrals of returning servicemen and women. The list will be made available to psychiatrists in the armed forces, to the American Red Cross, and other interested agencies.

"*Public Relations and Education.*—The third type of extended effort is engaged in by many kinds of organization. All have the common purpose of acquainting their constituency with the nature of the disabilities on account of which the men are being discharged from the armed forces. Included in such efforts have been several series of popular newspaper and magazine articles dealing with the subject of the psychoneuroses.

"Several mental-hygiene societies—Connecticut, Minnesota, Missouri, Illinois, and Charlotte, N. C.—have held institutes and other meetings in which this subject has been dealt with. Others have conducted courses:

"A course on 'Mental Hygiene for Industrial Nurses' held under the joint auspices of the Massachusetts Mental Hygiene Society and the State Department of Mental Health in Boston in November and December. Information can be obtained from Miss Bernice Henderson, Secretary, Massachusetts Mental Hygiene Society, 3 Joy St., Boston.

"Wisconsin Mental Hygiene Society has presented one course for personnel men and industrial nurses, the series being given in industrial

plants. A second series for families and citizens has been given in the same community. Each session of this course is attended by an increasingly large group of mothers, wives, small employers, and representatives of health, social, and civic organizations. Information can be obtained from Esther H. deWeerdt, Ph.D., Secretary, Wisconsin Mental Hygiene Society, 405 E. Grand Ave., Beloit, Wisconsin.

"Both the educational and the community-planning aspects of rehabilitation are receiving serious consideration in the meetings of state medical societies, state conferences of social work, and local councils for social planning. The director and field consultant of the division have participated in several of these.

"*Church Activities.*—The Federal Council of the Churches of Christ in America has published Number 1 in a series of pamphlets on 'The Church and Returning Service Personnel,' and several of the denominations are preparing material on the same subject.

"*Clinic Fees for Work With State Bureaus for Vocational Rehabilitation.*—The following quotation from Mr. Michael J. Shortley, Director of Vocational Rehabilitation, Federal Security Agency, will serve to answer inquiries received from several correspondents:

" 'The question concerning the establishment of fees for psychiatric diagnosis and examination is one that will of necessity have to be determined by each individual state rehabilitation agency. In the section on "Requirements and Recommendations for Physical Restoration Services" of the Manual of Policies recently distributed to all state agencies by this office, the recommendation is made (p. 23) that rates of payment to qualified public voluntary or private clinics should be based on estimates of cost where such figures are available. In general, this office urges the adoption of rates of payment that will insure the availability of competent medical care. These rates are expected to be fair and closely related to a reasonable estimate of cost, if accurate cost figures are not available.' "

Inquiries and correspondence directed to the Division of Rehabilitation of The National Committee for Mental Hygiene should be sent, *not* to the offices of The National Committee, but to Dr. A. C. Rennie, Director of the Division of Rehabilitation, The National Committee for Mental Hygiene, 525 East 68th Street, New York 21, N. Y.

The Division Neuropsychiatrist *

The assignment of a neuropsychiatrist to the staff of the division surgeon has been made necessary by the relatively high rate of neuropsychiatric casualties, especially in combat. It represents one of the most progressive moves yet made in military psychiatry. With the exception of induction centers and mental hygiene units in replacement training centers, psychiatric activity in the Army has been con-

* Prepared in the Office of the Surgeon General. Reprinted by permission from *The Bulletin of the U. S. Army Medical Department*, No. 74, pp. 29–34, March, 1944.

fined mostly to hospitals, with emphasis on diagnosis and disposition. In accordance with the policy of The Surgeon General, a new and more effective effort towards the development of preventive psychiatry has been placed in effect. The new division neuropsychiatrist will still have, however, an important responsibility in screening, diagnosing, and accomplishing dispositions. He will have also the opportunity to influence the placement of men, to work at mutual problems with the Judge Advocate and Provost Marshal, to be an advisor in training, and to work intimately with Special Services and morale officers.

A carefully selected group of officers has been assigned to this important duty. They have had from one to three years' experience in psychiatry in the military setting. Each will be the sole representative of psychiatry in a large combat team. It is hoped that this opportunity will prove to be one of the major contributions of psychiatry in the Army of the United States.

The functions of the division psychiatrist are set forth in Section V, War Department Circular 290, dated 9 November 1943. This circular outlines clearly the duties and responsibilities of the psychiatrist, but some review and comment are timely.

Ten specified functions are listed. One statement in the introduction deserves special comment: "The neuropsychiatrist is assigned solely to function as such." It is the intention of all concerned in planning this step that a literal interpretation be given this statement. It was demonstrated in World War I that the division neuropsychiatrist could function effectively only when he functioned as a staff officer. In one division, when the neuropsychiatrist was assigned to other routine duties, hundreds of minor neuropsychiatric cases were erroneously evacuated, thus wasting much man power which would have been saved had the neuropsychiatrist been available to care for those patients. Chapter 2, Section II, Volume X, of the Medical Department of the United States Army in the World War, deals with the division psychiatrist.

Each function of the division neuropsychiatrist listed in Circular 290 will be discussed.

1. *Advise in all matters pertaining to the mental health of the command.* The new division neuropsychiatrists, mostly, are fresh from assignments to Army hospitals. Their work has been with the sick; whereas, in the new assignments their chief concern will be with people who are well. From functioning strictly as clinical psychiatrists, now they must become primarily mental hygienists. While they will have ample opportunity for clinical work, their major interest must be to keep men healthy and fit as fighting soldiers. Their interest must change from the individual to the group. The neuropsychiatrist's influence must be exerted through every officer in the command.

The mental health of the division is their major function and must receive the majority of their thought, effort, and time.

2. *Maintain a continuous screening process for the purpose of detecting and promptly eliminating individuals emotionally unfit for military service.* As in hospital practice, the neuropsychiatrist will continue to eliminate unfit men. Perhaps he will be received in the division on the basis that this is his chief and most important function. As he is well acquainted with this procedure, this attitude may be fortunate, but it may also prove to be an unfortunate attitude since his chief effort is to salvage men for service. Certainly he will often be expected to "get rid" of men who he knows must be saved through his clinical judgment, skill, contacts, and influence. On this point, the neuropsychiatrist must reorient his thinking and point of view. True, earlier directives have made it mandatory for psychiatrists to discharge every soldier in whom a diagnosis of even psychoneurosis was made; but man-power shortage has become progressively acute. War Department Circular 293, 11 November 1943, is an attempt to reverse the former practice of wholesale discharge of men. It has become imperative that everything possible be done to salvage men for military service.

The neuropsychiatrist's duty, in part, will be to aid in the placement of men in job classifications in which they can function. For the first time the neuropsychiatrist has a chance to be a close advisor to the classification officer which in the hospital in large posts was not possible. Through the classification officer, the division neuropsychiatrist will have his first opportunity to guide the placement of his patient.

It is still important that a man who is definitely unfit for any job should not be kept in the Army and should be eliminated as soon as possible. But if he definitely cannot be a combat soldier, there are many other jobs in the Army and every effort should be made to salvage and place him properly.

3. *Be available for the early treatment of normal individuals who suffer from minor correctible maladjustments to Army service.* This function may be a new opportunity for many neuropsychiatrists. Even though it is the aim in the Army hospital, too few had the opportunity to carry on satisfactory therapy. The great majority of our patients were not seen in the earliest stages. In most hospitals the neuropsychiatric section was understaffed and the psychiatrists on duty were kept busy with consultations, making diagnoses, and making dispositions.

The division neuropsychiatrist probably will not have time for more than a minimal amount of individual psychotherapy; however, he should attempt as much treatment as he can—and as often as he can.

For the first time in the Army, he will have an opportunity in some degree to modify and influence the soldier's environment. He should contact the soldier's unit commander and his noncommissioned officers, and discuss their relationships to the soldier. The importance of arranging rest periods, modifying the daily program, and the granting of furloughs can be pointed out. The opportunity for affecting the morale of the unit will be limited only by the neuropsychiatrist's ingenuity. Group psychotherapy, camp newspaper articles, group discussions, all belong in any broad interpretation of "treatment." Here is placed in the neuropsychiatrist's hands an opportunity to treat remedial conditions without resort to hospitalization. Hospitalization can be reduced and the patient treated in a more favorable atmosphere where it is expected that he will return to duty. All of these considerations are in line with the growing policy of progressive military neuropsychiatrists in attempting to treat patients in the outpatient service and thus prevent hospitalization in numerous cases.

4. *Assist in a program of preventive psychiatry, especially in its relationship to discipline and morale, through educational programs and informal discussions with line officers and others who may seek his advice.* This directive not only indicates the neuropsychiatrist's personal responsibility for morale, but gives an important suggestion on how to carry it out. Morale might be regarded as synonymous with mental health, but morale also implies the group direction toward the accomplishment of an aim. There is a direct relation between the state of morale and neuropsychiatric casualties. This fact alone indicates the responsibility of the psychiatrist in the problems of morale.

Neuropsychiatrists are trained to be interested fundamentally in motivation of behavior. Although their clinical interests have been largely confined to the individual, many general principles can be applied to a group. The importance of security, confidence in leadership, group identification, gratification, appropriate direction of aggression, and other dynamic factors should be the educative concern of the psychiatrist. Of the greatest importance is the soldier's understanding of "why we fight."

This directive indicates the opportunity to contact line officers. This is paramount for the neuropsychiatrist. The better he knows line officers, the greater will be the opportunity to help them and for them to seek his advice. This will be particularly true if he will forget psychiatric jargon and explain his findings and recommendations in simple terms. If and when he demonstrates his personal firsthand knowledge of their problems and provides helpful suggestions for their solution, the neuropsychiatrist will become much in demand in the division. Only after he is oriented will the neuropsychiatrist

have some valuable and important suggestions or partial answers. As the directive suggests, he should participate in every group activity and every educational effort and training, both formal and informal. It is his assignment to do all in his power to influence the morale of the whole division.

5. *Facilitate reclassification procedures to assure as far as practicable the proper assignment of personnel.* The division neuropsychiatrist will be in a position to recommend the proper assignment of misplaced personnel. Improper placement is a factor in poor mental health. Each division has a classification officer, often a competent psychologist, whose duty is to have full knowledge of the various job classifications and vacancies in them. He is fully aware of the necessity of proper placement and will be anxious to carry out the recommendations of the neuropsychiatrist. He should be one of the earliest contacts and one of his closest contacts. Together they should form a team through which it will be possible to assign men in the division correctly. Only with his help can the neuropsychiatrist perform his highly important job of salvaging men.

6. *Be available as consultant to courts-martial and other boards where his services are indicated.* In the hospital experience, serving with or on boards was an onerous job which required much time, was often irritating, and left one feeling that little good was accomplished. In courts-martial and Section VIII boards this was partly because of frequent changes in personnel of the board, each contact requiring a new start.

These objections will not be true, for the most part, in the division. In most instances, semipermanent boards are established; it will be the neuropsychiatrist's unit; and perhaps most important, it is a special opportunity to educate the officers on the board in psychiatric principles. Now they will be his own officers. It will be well for the neuropsychiatrist to recast his attitude towards boards.

7. *Visit division dispensaries and advise in management of psychiatric and psychosomatic problems.* A close working relationship with and the confidence of the division surgeon are essential. Only slightly less important are the good will and coöperation of the other medical officers in the division. The visitation of the dispensaries and a regular appointment and time spent in each will pay dividends in opportunities to teach and practice psychiatry. Most medical officers will welcome instruction in psychiatric and psychosomatic problems. Remember that sick call is often an important barometer to the mental health of the command. Also he may be helpful to other medical officers in emergency situations as a physician. This will be returned in large measure when the neuropsychiatrist will need their help in treating battle casualties.

Each psychiatrist is simultaneously a soldier, an officer, a physician, and a psychiatrist in that order. The assignment to a combat division carries responsibilities. Being an officer is synonymous with being a leader; it means a primary interest in the group and participation in a team. The adjustment from civic life to Army existence is a difficult adjustment for new medical officers, but it is essential to the team effort. Being primarily a physician before being a specialist should be axiomatic in or out of the Army. In civil life, the physician dealt with individuals; in the Army he must be concerned primarily with the group. Finally, the psychiatrist is assigned to the division because he is a psychiatrist. There is no doubt that, for the psychiatrist, psychiatry is his field of greatest usefulness. The chances are that he may never see the occasion when there is any conflict in being simultaneously a soldier, an officer, a physician, and a psychiatrist.

8. *Supervise the maintenance of proper records of neuropsychiatric conditions within the command to the end that adequate information accompanies each patient evacuated to the rear.* The good psychiatrist keeps good records. Their importance in the subsequent care of soldiers should be a continuous goad to do one's best, despite handicaps. Forward medical echelons have developed short, practical forms.

9. *Keep constantly oriented to the changing psychiatric problems during training, precombat, and combat periods, with a view towards developing the mental toughness essential to combat troops.* To know your job means to live with the men, to do what they do, to experience personally their problems and struggles. It means that to be effective he needs to shoot their weapons, ride their vehicles, participate in their bivouacs, take their infiltration courses. In addition to so educating himself, the neuropsychiatrist's interest and participation will gain the respect of the soldier who realizes that the doctor fully understands his problems. It will place him in a most advantageous position which he can get in no other way, being able to apply most effectively his psychiatric skill and judgment to problems of training and combat.

10. *Supervise the management of neuropsychiatric casualties during combat.* In heavy combat the neuropsychiatric casualties are numerous. Treatment, to be effective, must be as far forward as possible. The directive states that the neuropsychiatrist is "to supervise" their management. Experience indicates that any divisional medical officer may be called on to treat neuropsychiatric cases. For this reason, early efforts in educating them to the rationale and methods are strongly indicated. During the training period, and with an eye to the future, it may be advisable to train one or more enlisted men as assistants. The rationale and method of treatment are described

completely elsewhere (S.G.O. Circular Letter 176, dated 20 October 1943).

Division neuropsychiatrists go into their new jobs as pioneers, missionaries, educators, and salesmen. Each one can be a most important factor in the success of a division. They are expected to write a great chapter in American psychiatry.

New Plan of Selection for the WAC

The United States, when it started to build a women's army, was undertaking a relatively new venture. It has had the courage, however, to face its limitations of experience and to attempt to improve its process of selection and training as it has moved ahead. Selection has not always been successful, and one maladjusted woman can lower the morale of the whole company and thereby have a deterrent effect upon recruiting. In March, 1944, a new plan of selection of applicants for enlistment in the WAC was instituted. This consisted of adding to the physical examination, the intelligence test, and the interviewing, the securing of sufficient data to give an authentic picture pertinent to the question of qualification for the WAC. It would have been very easy to have stimulated recruiting by lowering the standards of admission to the WAC, but the army chose the course that was more difficult, at least in the beginning, and raised the standards, making acceptance in the WAC something of an achievement and an honor. As a result of this change, admission to the Women's Army Corps has become selective, discriminative, and something of a distinction. A higher level has been set for our young womanhood to strive for.

Army Takes Over Mason General Hospital

On June 22 the Mason General Hospital at Brentwood, L. I., N. Y., was turned over formally to the Medical Corps of the United States Army, and dedicated to the recovery of psychoneurotic casualties both from battle and from training areas. The hospital was built by the state of New York as a unit of the Pilgrim State Hospital, which it adjoins. It can house 1,348 patients normally and 2,000 in an emergency.

The army has established here its special school for training medical officers in psychoneurology. It already has 1,000 on such duty and will add the graduates of the classes that will go through the hospital every three months. These graduates will go directly to the front. The faculty of the school is headed by Colonel William C. Porter.

Colonel Cleve C. Odom is the commanding officer of the hospital, which was named in honor of Brigadier General Charles F. Mason, who died in 1922 after a distinguished career in the Medical Corps.

Bishop Wroth Heads Mental-Hygiene Committee

A community plan to aid in the rehabilitation of mental casualties of World War II is revealed in the announcement that a charter has been granted in the Warren County Court of Common Pleas to the newly formed Mental Hygiene Committee of Northwestern Pennsylvania. The area to be served by this program (coextensive with the areas served by Warren State Hospital) covers, the charter shows, Clearfield, Clarion, Jefferson, Cameron, Elk, McKean, Crawford, Mercer, Venango, Erie, Forrest, Potter, and Warren counties. Bishop E. Pinkney Wroth, of the Erie Episcopal Diocese, heads the organization. Other members of the executive committee are District Attorney Edward J. Blatt, of Elk County; Rev. A. J. During, of McKean, Pa.; and Dr. E. S. Briggs, Dr. W. Earl Biddle, and Mr. Cecil C. Winans, of Warren, Pa.

Formation of the plan was stimulated by the growing realization of the extent of mental and nervous diseases both in civilian life and in military service. The discovery that one-third of the rejections made by Selective Service examinations and one-third of the discharges from military service have been for mental and nervous disorders prompted the action. Less well known, but also alarming, have been the number of difficulties arising in industry, schools, churches, courts, and general hospitals because of emotional disturbances which, if untreated, may lead to mental disorder.

The committee plans to enlist the resources and support of its member counties to develop the purposes described in its charter. These purposes are: to enlighten and direct public opinion in the knowledge of the nature of mental illness; to reduce the incidence of mental and nervous disorders; to supplement and stimulate the efforts of those existing agencies engaged in the study and care of the mentally ill.

Further development of the district program is now under way. It is learned that outstanding civic leaders have been enlisted in each of the thirteen counties to contribute to the extension of the organization's work.

A Psychoanalytic and Psychosomatic Clinic Established at Columbia University

The establishment, in the Columbia University Department of Psychiatry, of a psychoanalytic and psychosomatic clinic for training and research, has been announced by Dr. Willard C. Rappleye, Dean of the Faculty of Medicine.

The new clinic, the first of its kind in the United States, is under the supervision of Dr. Nolan D. C. Lewis, Executive Officer of the Department of Psychiatry at Columbia University and

Director of the New York State Psychiatric Institute and Hospital. Dr. George E. Daniels, Clinical Professor of Psychiatry, has been appointed Chief of the Psychosomatic Service. Dr. Daniels is Chairman of the Committee on Research in Psychosomatic Medicine of The National Committee for Mental Hygiene.

The clinic, which opens in October, is to be located at the Columbia-Presbyterian Medical Center, New York City.

Qualified physicians who are graduates of an approved medical school and who have completed an approved hospital internship of not less than one year, will be required to undergo a psychoanalysis in order to be admitted to the three-year course of resident graduate training in psychoanalysis and psychosomatic medicine.

The course of training includes a systematic program of lectures and seminars, clinical conferences, and supervised clinical work on the psychoanalytic and psychosomatic services. It is combined with two years of resident graduate study in the other branches of psychiatry, with emphasis on the related basic medical sciences.

Those who meet the requirements may register for the degree of Doctor of Medical Science. Upon completion of an acceptable, original, and previously unpublished dissertation on the laboratory or clinical aspects of the specialty, and satisfactory completion of written, oral, and practical examinations in the related clinical and laboratory fields, the candidate may be recommended for the degree of Doctor of Medical Science.

New School for Social Research Offers Two Child-Study Courses

Two courses of special interest to public-health workers are scheduled to open at the New School for Social Research at 66 West 12th Street this fall.

Because of the urgent demands for intelligent workers in child-care centers, a fifteen-week course, which will run through both the fall and spring terms, is being given by Eleanor Reich and the staff of the Harriet Johnson Nursery School. This course is highly practical and aims to give teachers, parents, nurses, and volunteers in the field a clearer understanding of the needs of young children. The second-semester course will be an advanced seminar. The course will be held on Monday evenings at 8:30.

Dr. Lawrence Joseph Stone, on leave from the Psychology Department of Vassar College to do special work for the U. S. Maritime Commission, is offering a two-semester course on child psychology. This course, which provides a practical method of studying each child's individuality, his rate of growth, his food preferences, and

how to foster his personality, is intended to help parents, teachers, nurses, social workers, and professional students.

Films and research materials, including many from the Vassar Child Study Department, will be drawn upon extensively for demonstration. The course is to be held on Tuesday evenings at 8:30.

Two Conferences on Reading Problems

The Reading Clinic Staff of the School of Education, The Pennsylvania State College, State College, Pennsylvania, is sponsoring two important meetings on reading problems during 1945.

The Annual Seminar on Reading Disabilities will be held from January 29 to February 2, 1945. Demonstrations and discussions on a differentiated program for analyzing and typing, or classifying, reading disabilities will be conducted by the staff of the reading-analysis unit of the reading clinic. Remedial techniques will be demonstrated and discussed by the staff of the reading-clinic laboratory school. A number of visiting speakers and demonstrators have been included. The program has been planned to interest remedial teachers, school psychologists, speech teachers, neurologists, otologists, and vision specialists.

From June 26 to June 29, 1945, the reading-clinic staff will conduct the annual conference on reading instruction. This conference deals with classroom problems. The activities are differentiated for elementary and secondary teachers, college teachers, special-class teachers, speech teachers, and school psychologists.

Copies of the program and information on transportation schedules may be obtained from Miss Betty J. Haugh, Reading Clinic Secretary. Those desiring college credit, especially graduate-school credit, for the seminar should register in advance with the director of the reading clinic.

A Mental-Health Rehabilitation Program for the State of Washington

The Medical Association of the State of Washington is planning to inaugurate, in conjunction with the state department of health, a state-wide mental-health program for the rehabilitation of discharged service men whose cases are not covered by the Veterans Bureau. A committee on mental hygiene has been appointed by the state medical society to act as an advisory committee to the state department of health. The plan provides for three teams, each composed of a psychiatrist, a psychologist, and a psychiatric social worker.

Susceptibility of Mental Defectives to Mental Disease

"We are now in a position to state positively that the general rate of incidence of mental disease is higher among subnormal persons than among the general population and that the *rate* of *mental disease declines as the degree of intelligence* advances." This statement was made at the May meeting of the American Psychiatric Association in Philadelphia by Dr. Horatio M. Pollock, former director of the Statistical Bureau of the New York State Department of Mental Hygiene.

The reasons advanced by Dr. Pollock for the high rate of mental disease among mental defectives were that "mental defectives are poorly equipped to withstand stresses of unusual character; they have difficulty in resolving their mental conflicts; because of a lack of social competency and a susceptibility to suggestion, they get into all sorts of difficulties; and many are so emotionally unstable that they lose all control of themselves in unusual circumstances."

Since it is apparent that in mental defectives we have a group of persons especially susceptible to mental disease, it is unfortunate, Dr. Pollock said, that this fact has not been taken into consideration in our general treatment of subnormal children. More thought must be given to the mental-hygiene needs of mental defectives, both within and without institutions. To do this will require "the well-guided, coöperative effort of teachers, social workers, public-health nurses, psychologists, and psychiatrists."

Dr. Humphreys Appointed Michigan Director of Mental Hygiene

Dr. Edward J. Humphreys, former Director of Research at Letchworth Village, Thiels, N. Y., and more recently Assistant Superintendent of the State Home and Training School, Coldwater, Michigan, has been appointed Director of Mental Hygiene of the State of Michigan. Dr. Humphreys succeeds Dr. Frank F. Tallman, who resigned to become director of a similar position in the Ohio State Department of Health. Four child-guidance clinics established by the Michigan legislature will begin functioning this fall in Wayne County, Pontiac, Grand Rapids, and Ypsilanti.

Dr. Howard K. Petry New Director of Pennsylvania Bureau of Mental Health

Dr. Howard K. Petry, Superintendent of the Harrisburg State Hospital, has been appointed Director of the Bureau of Mental Health of the Pennsylvania Department of Welfare. He succeeds Dr. William C. Sandy, who retired from this position July 1, 1944.

Prior to becoming superintendent of the Harrisburg State Hospital, Dr. Petry was connected with other mental hospitals in

Pennsylvania. He has been chairman of the Committee on Mental Hygiene of the Pennsylvania State Medical Society for many years. Governor Martin has recently appointed him chairman of a committee to make a survey of conditions in Pennsylvania mental hospitals. He will continue to serve as superintendent of the Harrisburg State Hospital.

State Society News

Alabama

The Alabama Society for Mental Hygiene has been sponsoring a series of radio talks by various speakers on the general topic, "Mental Health Problems of the General Population and the Returning Soldier." Dr. J. E. Bathurst, of Birmingham Southern College, who is president of the society this year, has been largely responsible for the development of the program.

Mrs. Alva Sharpe, of the Children's Society, is the new vice president of the Alabama Society. Mrs. Katherine Vickery continues as secretary-treasurer.

California

The Mental Hygiene Society of Northern California is doing everything within its ability to insure the passage, at the next legislative session, of a new commitment law for California. It is organizing county committees to mobilize support for the bill throughout the state, as well as arranging for a state-wide conference of representatives of all organizations that may take an active part in the campaign.

The society has arranged a seminar on problems of returning servicemen for staff members of the United States Employment Service offices in the Bay Area counties. The seminar, consisting of fifteen two-hour lectures, will be given under the auspices of Stanford University.

A joint executive meeting of the Northern and the Southern California Societies will be held at San Luis Obispo on October 7, for the purpose of developing ways and means by which the two societies may work together on state programs.

The Southern California Society for Mental Hygiene has established a study committee on psychiatric rehabilitation for ex-service men. Dr. Burrell C. Raulston, Dean of the School of Medicine, University of Southern California, will act as chairman of the committee, whose function it will be to determine the needs as they exist in the various committees, to analyze present facilities and available resources, and to formulate a plan by means of which the resources can be made to approximate the needs.

Hawaii

The following report on the activities of the Hawaii Territorial Society for Mental Hygiene comes from Mrs. Dorothy Anthony, the society's executive secretary:

> "The society has continued its program of education in the basic concepts of mental hygiene through a series of monthly lectures for the members and the interested public. There were four talks in the first series beginning with *What Is Mental Hygiene?*, followed by *Why Human Beings Behave as They Do, What Is Mental Illness?*, and *The Social Setting as a Factor in Mental Hygiene.* These talks were interesting and well attended. Two of them have been published in the *Hawaii Educational Review*, a monthly periodical that is sent to every teacher and parent-teacher group in the Islands. Reprints of the first talk were mailed to the members and we expect to send them reprints of the last one.
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> "Beginning this month, the society is sponsoring a second series. Dr. Pauline Stitt, now connected with the board of health and formerly a pediatrician on the staff of the Edward J. Meyer Memorial (Buffalo City) Hospital and director of its child-guidance clinic, will start the series with a talk on 'The Mental Hygiene of Childhood.' Dr. Larsen will then discuss 'The Mental Hygiene of Adolescence,' and the director of pupil guidance in the department of public instruction will lecture on 'Mental Hygiene in the Schools.'
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> "At the annual two-day session of the Territorial Conference of Social Work held recently, the society was responsible for planning one of the afternoon meetings and presented three papers on 'The Mental Hygiene Aspects of Rehabilitation.' Dr. R. D. Kepner spoke on the subject 'What War Does to Service Personnel.' Dr. Shanahan, who followed him, discussed 'Planning for Social and Mental Adjustment of Servicemen Returning to the Community.' The last participant, the president of the Honolulu Council of Social Agencies, summed up 'Community Facilities for Handling These Problems.' From reports that have reached us, the large audience considered these talks most instructive and timely.
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> "The results of the membership campaign that we got under way in the middle of January were encouraging. We added 260 individual members and 13 agency members to our original list of approximately 100. This was the society's first effort to broaden participation in our activities through an enlarged membership, particularly among lay persons. We still need many additional members if we are to do effective work, because practically all of our funds are derived from membership fees and, as you know, it takes a great number of two dollars to pay our rent, the salary of a half-time stenographer, and other expenses. We have been the recipients of contributions from four firms in Honolulu. Whether these will be annual gifts, remains to be seen."

Louisiana

The July issue of the *Mental Health News*, the bulletin of the Louisiana Society for Mental Hygiene, contains an outline of the provisions of the recently passed Mental Health Bill, Act No. 303,

which, the *News* states, "marks the greatest progress in the care and treatment of the mentally ill in the history of Louisiana. Predicated on principles which should govern the care of mental patients, the Act provides for immediate hospitalization, specialized care, and early discharge, upon recovery, under conditions which will speed rehabilitation of patients."

An editorial in the same issue of the *News* expresses warm appreciation to all those whose efforts contributed to the passage of the bill: to the 1942 Legislature, which authorized the appointment of a commission to study the mental-health laws of the state, and to the 1944 Legislature for the passage of the Act; to Governor Davis; and to a long list of doctors, lawyers, newspaper men, and others whose time and special skills, given without compensation, helped to make the Act possible.

Minnesota

The Minnesota Mental Hygiene Society announces the election of the following officers for the coming year: President, Miss Anne Starke; Vice President, Dr. Philip H. Heersema; Secretary, Mrs. Jane Chalmers; Treasurer, Dr. Clarence P. Oliver; Executive Secretary, Mrs. Carl Lefevre. Dr. Lippman will continue as chairman of the society's clinical section, and will be the society's representative on the Mayor's Planning Committee in St. Paul. Dr. Harold Hansen, Dr. Alexander Dumas, and Dr. Starke Hathaway will continue to serve on the Central Executive of the Minneapolis Veterans Referral Office. A new section, under the chairmanship of Dr. Hathaway, is being considered for action by the board at its next quarterly meeting.

With a legislature year coming up, the society is laying the ground work for a study and recommendations and expects to have a competent committee functioning actively and *ex officio*.

Wisconsin

Dr. Leonard E. Himler, of the University of Michigan Student Health Service, is to be the speaker at the annual meeting of the Wisconsin Society for Mental Hygiene, which will be held at the Hotel Schroeder, Milwaukee, on October 26. For a number of years it has been the practice of the society to hold its annual meeting in conjunction with the Biennial Conference or institutes sponsored by the Wisconsin Welfare Council, formerly the Wisconsin Conference of Social Work. This year the meeting will be in conjunction with the Biennial Conference.

The Wisconsin Society has prepared two series of four talks each on the adjustment of returning service men who are nervous or mentally upset. One series, *Adjusting the Nervous and Mentally*

Upset Employee to His Work, is for employment and personnel men and women, industrial nurses, and management; the other, *Psychology for the Ex-Service Man and His Family,* is for relatives and friends of service men and women.

In a folder directed to employers the Wisconsin Society announces that it is prepared:

> "1. To conduct short discussion courses which present basic principles and practical psychological aids.
> "2. To provide consultation service on personnel problems dealing with the adjustment of 'nervous' workers.
> "3. To present demonstrations in studying and interpreting the mental and emotional problems of the worker.
> "4. To supply information on mental, trade, and aptitude tests.
> "5. To recommend local and state sources of reliable leadership and information and practical speakers on mental health topics.
> "6. To prepare and publish pamphlets on special topics that are the subject of inquiry.
> "7. To keep personnel men and women advised as to the programs of those welfare services particularly adapted to meet the needs of the worker.
> "8. To serve as a research and exchange agency for collecting and relaying information and experience of industries and communities in Wisconsin and elsewhere as rehabilitation programs are developed."

New Publications

Three booklets, containing the proceedings of the Second Brief-Psychotherapy Council, held in Chicago, January 1944, have been issued under the auspices of the Chicago Institute for Psychoanalysis. Booklet No. 1, *War Psychiatry,* has articles by Murray, Grinker, Miller, Mittelmann, Beck, Harrower-Erickson, Wells, and Blain. The articles in No. II, *Psychosomatic Medicine,* are by Barach, French, Weiss, Daniels, and Alexander. No. III is in two sections—*Psychotherapy for Children,* with articles by Putnam, Sylvester, Sterba, and Ziss; and *Group Psychotherapy,* with articles by Redl, Lewin, and Moreno. Copies of the booklet can be obtained from the Institute of Psychoanalysis, 43 East Ohio Street, Chicago, Ill.; single copy $.75, set of three, $2.00.

The *Quarterly Journal of Studies on Alcohol* has added three new titles to its list of "Lay Supplements"—No. 10, *The Drinker and the Drunkard;* No. 11, *How Alcohol Affects Psychological Behavior;* and No. 12, *The Rehabilitation of Inebriates.* Two additional pamphlets are in preparation. The prices of the Lay Supplements are $.10 each; $1.00 per set of fourteen; $5.00 per hundred of each Lay Supplement. Subscribers to the full set of fourteen receive each additional supplement as it is published. Orders should be addressed to the *Quarterly Journal of Studies on Alcohol,* Edi-

torial office, Laboratory of Applied Psychology, Yale University, 4 Hillhouse Ave., New Haven, Conn.

Announcement has been made of the publication, beginning in January 1945, of a new quarterly in the field of clinical psychology. The *Journal of Clinical Psychology,* as the new publication will be called, will be a scientifically oriented professional journal limited to the publication of original research reports and authoritative theoretical papers. It is being published after two years of study and planning in response to the need for a scientific journal dedicated to the advancement of the clinical method in psychology. Dr. Frederick C. Thorne will be the editor of the journal, whose editorial and business offices will be at the Medical College Building, University of Vermont, Burlington, Vermont.

A special number of the *Anals da Colonia Gustavo Riedel* has recently been issued, dedicated to the memory of Dr. Gustavo Riedel, founder of the Brazilian League for Mental Hygiene, whose death occurred ten years ago. A notice of the death of Clifford Beers appears in the same issue; and the next issue, it is announced, will contain material of interest by Mr. Beers, believed to be hitherto unpublished.

Reprints of the following articles in the July issue of MENTAL HYGIENE are available: *The Moral Outlook of the Adolescent in War Time,* by Peter A. Bertocci; *The Psychologist Working with Crippled Children,* by Ruth M. Hubbard; and *The Mental Hygiene of Owning a Dog,* by James H. S. Bossard. Price: $.10 a single copy; $7.50 per hundred.

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GENERAL PURPOSES

The National Committee for Mental Hygiene [illegible] through its associated state societies and local committees, [illegible] for the conservation of mental health; for the prevention of mental [illegible] diseases and mental deficiency; for the improvement [illegible] and treatment of those suffering from mental disease and the special [illegible] and [illegible] deficiency [illegible] minded; and for the acquisition and dissemination of [illegible] these subjects and [illegible] factors [illegible] in the [illegible], delinquency, dependency, and [illegible] related to [illegible] behavior. The Committee [illegible] its [illegible] research into [illegible] mental deficiency; [illegible] applying the [illegible] through [illegible] the promotion of [illegible] child-[illegible] in the [illegible] governmental and [illegible] of any [illegible] of mental hygiene.